Susan J. Anderson, PSY.D., PA

3965 W.83rd Street #338 Prairie Village, Kansas 66208

Phone: 913-353-5993 Fax: 844-800-3062

www.drsusanjanderson.com

**NEW CLIENT REGISTRATION FORM**

**Section I**

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial \_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Identified Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FINANCIALLY RESPONSIBLE PARTY (If different from above)

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT INFORMATION

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section II FINANCIAL POLICY**

* You MUST HAVE YOUR INSURANCE CARD at the first INTAKE appointment. It is your responsibility to provide any insurance changes to me including any prior authorizations.
* If your insurance company requires prior authorization and you have not obtained this, YOU are financially responsible for the FULL FEE at the time of service. It is your responsibility to contact your insurance company to determine your outpatient mental health benefits.
* A credit card will be kept on file encrypted for copays, deductibles, and any fees.
* While reasonable efforts are made to directly collect unpaid balances, Dr. Anderson’s practice utilizes Kansas Counselors, Inc, (KCI) collection agency to collect unpaid balances (this may impact your credit score if not addressed.)

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE STATEMENT.

Client Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Initialed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please initial one of the following:

\_\_\_\_\_\_\_\_\_\_ I am a PRIVATE PAY CLIENT – I am responsible for full fee the date of service.

OR

\_\_\_\_\_\_\_\_\_ I authorize payment from my insurance company to Susan J. Anderson, Psy.D.,PA. I further authorize to my insurance company any medical or other information necessary to process my insurance claims. I understand I am responsible for all balances not paid by my insurance company including but not limited to deductibles, coinsurance, copays and late fees.

Client Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Initialed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Using an EAP Policy (EMPLOYEE ASSISTANCE PROGRAM)

I understand that if I am entitled to the benefits through EAP, I must present the billing information and authorization number for that benefit AT THE FIRST APPOINTMENT. If during the course of my treatment, I find out I was entitled to an EAP benefit that I was unaware of, Dr. Anderson will begin the benefit with the NEXT SESSION provided I have obtained authorization regardless of the beginning date of the authorization.

Client Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Initialed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NO SHOW AND LATE CANCELLATION POLICY

I understand I will be charged the FULL SESSION FEE (insurance amount & any copay) for a missed appointment or if I cancel an appointment with less than 24 BUSINESS DAY hours of advanced notice. I understand Dr. Anderson does not make reminder calls prior to appointments. I understand it is my responsibility to keep track of my appointments.

Client Initials \_\_\_\_\_\_\_\_ Date Initialed\_\_\_\_\_\_\_\_

**Section II I INSURANCE & POLICY HOLDER INFORMATION**

Primary Policyholder is: Self\_\_\_\_\_\_\_\_\_ Spouse\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_

* If the primary policyholder is someone other than yourself, please complete the following:

Primary Policyholder’s:

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial \_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_Zip \_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Company Name is\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Authorization Information if using EAP

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section IV INFORMED CONSENT**

CONSENT FOR TREATMENT: Please read through this document carefully and note any questions you have so that we may discuss further. Once you have signed this agreement page, it constitutes a binding agreement between us.

PSYCHOTHERAPY: Psychotherapy can involve a number of different approaches. Outpatient psychotherapy is voluntary and requires an active effort on your part. Psychotherapy has both benefits and risks. It can often lead to a significant reduction of distress, improved relationships, and improvement or resolution to specific problems. It also sometimes requires recalling unpleasant aspects of your history and sometimes this means you may initially feel uncomfortable before you feel better. By the end of the INTAKE session, you should have a sense of what our work will involve.

SESSIONS: Sessions are 50 minutes long. If you are late to your session, this is time lost in your treatment. You are responsible for FULL payment of all sessions you schedule unless you give the required 24 business hour cancellation notice.

TELEMEDICINE/TELEHEALTH: By signing this consent, you are consenting to engage in telemedicine with Dr. Anderson. Dr. Anderson has purchased and is using a HIPAA COMPLIANT platform designed specifically for telemedicine providers. (This is not akin to FaceTime, Skype, or other social media platforms which do not meet HIPAA requirements.)

* You are agreeing to download software or utilize a platform with broadband internet connection at home or in a secure/private environment (not a public venue, moving vehicle, or place where our discussion can be seen or heard.)
* You are to treat these sessions AS IF we are sitting in a clinical office. This means being physically and mentally present (no multi-tasking i.e., doing household chores or getting ready for work, texting on your phone) as these activities are distractions to our therapeutic work and disrespectful to the therapeutic relationship.
* You are a resident of Kansas. (Traditionally Dr. Anderson can only provide telemedicine to clients who reside in the state of Kansas where she is licensed.
* You are in agreement with Dr. Anderson that sessions WILL NOT be recorded by either party.
* You are accepting there could be interference or technical issues that interrupt services.
* You are responsible for being on time for your virtual session. Dr. Anderson will not wait for you to be ready and you will still be charged the full fee.
* You recognize the telemedicine format may not be right for all clients and therapeutic needs may change. You have the right to withdraw your consent for telemedicine at any time.

CORRESPONDENCE: I acknowledge that electronic communication such as Email and texting can be compromised and are NOT HIPAA Compliant if I decide to communicate with Dr. Anderson using these. I am aware that Dr. Anderson has a fax number which IS HIPAA Compliant.

CONFIDENTIALITY: In general, most communication between you and your therapist is confidential. There are exceptions to confidentiality. These will be reviewed at intake and can include: a signed Release of Information (ROI), some court or legal issues, threat of suicide or serious harm to self or others, and cases of possible abuse to a child, the elderly, or a disabled person.

REQUIRED SIGNATURES

Signature of Client or Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRESENTING CONCERNS

What are the primary concerns, symptoms, or issues that sought you to seek help now?

These problems are: Mildly Upsetting \_\_\_\_\_\_\_\_ Moderately Severe \_\_\_\_\_\_\_\_\_\_\_

Very Severe \_\_\_\_\_\_\_\_\_\_\_ Totally Incapacitating \_\_\_\_\_\_\_\_\_\_

How long have these been a problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated for these problems before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of previous care: Inpatient \_\_\_\_\_\_ Partial or Day Treatment \_\_\_\_\_\_\_Outpatient \_\_\_\_\_\_\_\_

Has there ever been an attempted suicide? Yes \_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any current suicidal ideation? Yes \_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any plan for suicide? Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any family history of psychiatric problems or diagnosis? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_

If yes, please describe.

Please list any physical or medical issues and medications:

Are there any current Legal Concerns Yes \_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_

If yes, please describe.

Please feel free to address any additional information and concerns you feel I should know.

Client or Parent/Guardian Signature & Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Psychologists are required to provide the *option* of coordinating care with your primary care physician. Please note we can always sign a release in the future if wanted or needed.

Please choose one of the following:

1. **I DO NOT authorize** Dr. Anderson to exchange information with my PCP.

Client Signature and Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OR

1. **I DO authorize** Dr. Anderson to exchange information with my PCP.

Client Signature and Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Practice \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOR OFFICE USE ONLY

This is an: Initial Summary \_\_\_\_\_\_\_Interim Summary \_\_\_\_\_\_\_Termination Summary \_\_\_\_\_\_\_

Suggested Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reported Current Psychiatric Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment Goals \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment Modality

Individual Therapy \_\_\_\_\_\_\_\_ Group Therapy \_\_\_\_\_\_\_\_ Family Therapy \_\_\_\_\_\_\_\_

Couples Therapy \_\_\_\_\_\_\_\_ Psychiatric Consultation \_\_\_\_\_\_\_\_ Community Referral \_\_\_\_\_\_\_\_

Clinician Signature and Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Notice of Therapist's Policies and Practices to Protect the Privacy of Your Health Information** THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.   1. **Uses and Disclosures for Treatment, Payment, and Health Care Operations**  I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:  * "PHI" refers to information in your health record that could identify you. * "Treatment, Payment, and Health Care Operations" * Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another therapist. * Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. * Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. * "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. * "Disclosure" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.  1. **Uses and Disclosures Requiring Authorization**  I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.   You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.   1. **Uses and Disclosures with Neither Consent nor Authorization** I may use or disclose PHI without your consent or authorization in the following circumstances:  * Child Abuse - If I have reason to suspect that a child has been injured as a result of physical, mental or emotional abuse or neglect or sexual abuse, I must report the matter to the appropriate authorities as required by law. * Adult and Domestic Abuse - If I have reasonable cause to believe that an adult is being or has been abused, neglected or exploited or is in need of protective services, I must report this belief to the appropriate authorities as required by law. * Health Oversight Activities - I may disclose PHI to the Kansas Behavioral Sciences Regulatory Board if necessary for a proceeding before the Board. * Judicial and Administrative Proceedings - If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case. * Serious Threat to Health or Safety - If I believe that there is a substantial likelihood that you have threatened an identifiable person and that you are likely to act on that threat in the foreseeable future, I may disclose information in order to protect that individual. If I believe that you present an imminent risk of serious physical harm or death to yourself, I may disclose information in order to initiate hospitalization or to family members or others who might be able to protect you. * Worker's Compensation/Disability - I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.  1. **Patient's Rights and Psychologist's Duties**  * Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request. * Right to restrict certain disclosures of PHI to your health plan if you pay out of pocket for the healthcare service. * Right to Receive Confidential Communications by Alternative Means and at Alternative Locations - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.) * Right to be notified if there is a breach of your unsecured PHI. * Right to Inspect and Copy - You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process. * Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process. * Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process. * Right to a Paper Copy - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically. * I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. * I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. * If I revise my policies and procedures, I will provide you with a revised notice. * I must obtain a signed authorization before I can release your PHI for any uses and disclosures not here described.   5. **Complaints** If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.  6. **Effective Date** This notice will go into effect on Jan 01, 2022  I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND WHAT IT CONTAINS.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Nam  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Witness  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date |
|  |