PROFESSIONAL DISCLOSURE STATEMENT

JILL CONRAD, M.A., L.M.F.T

Address: Salem Pastoral Counseling Center
2001 Commercial St. SE, Suite 200
Salem, Oregon 97302
Telephone: (503) 370-8050 x 210
Email: Jill@salempastoralcounseling.org

Philosophy and Approach: I hold the belief that each individual is valuable and unique with the ability to change. Life is not static, but constantly changing and presenting challenging circumstances that often leave us feeling hopeless, powerless, and stuck in our relationships with others. My goal is to meet individuals and families where they are and walk alongside them as they strive to cultivate a deeper and more meaningful connection with one another. As a therapist who considers how our early experiences may have shaped us, I do find value in exploring your history and what role this plays in your life today. I employ an integrated systemic approach with a focus on attachment theory and EFT. While I am affiliated with a christian counseling center, I think it is important for a potential client to understand that I place high place high value in honoring your beliefs and perspectives should this be something you wish to discuss in therapy. I do not impose my personal beliefs on my clients and I am committed to operating within each individual's belief system. Areas of interest include: Helping families cope with severe mental illness, past addictions, teens, grief and loss, depression/anxiety, lifecycle transitions, and personal exploration for those seeking to better understand themselves and experience deeper connections with those around them. I hope to be a safe space as I understand the courage it takes to embark on this journey.

Formal Education and Training: My professional development involved studies at George Fox University where I received my undergraduate degree in Sociology in 2002. I received my Masters in Marriage and Family Therapy from Bethel University in San Diego, California in 2007. I have gained broad experience working in crisis and short-term treatment with individuals and families. I was employed in San Diego at a large inpatient psychiatric hospital where I worked with those suffering from both acute and chronic mental illness, substance abuse/recovery, and PTSD for vets returning from the war. I spent 10 years working on the Psychiatry team in the emergency department of the Salem Hospital where I provided emergency mental health evaluations. I have 12 years of experience in private practice which has been my focus of care since 2019.

As a licensee of the Oregon Board of Licensed Professional Counselors and Therapists, I abide by the code of ethics of the organization.

To maintain my status as a licensed therapist, I am required to participate in continuing education, attending educational seminars dealing with subjects relevant to this profession.

Fee Schedule : Fees for counseling services are $195.00 for the initial session and $165.00 for each subsequent individual session. Some adjustment in fees is possible in cases of need and when discussed in advance with the counselor.

Client Bill of Rights

As a client working with me, you have the following rights:

1. To obtain a copy of the Code of Ethics for the Oregon Board of Licensed Professional Counselors and Therapists.
2. To privacy as defined by rule and law, including the exceptions to confidentiality of information obtained in the course of services that include the following: *reporting suspected child or elder abuse, *reporting imminent danger to clients or others,
   *court-ordered release of information, *providing information concerning licensee case consultation or supervision, and *defending claims brought by client against licensee.
3. To be informed of the cost of professional services before receiving the services.
4. To be free from discrimination on the basis of race, religion, gender, or other unlawful category in receiving services.
5. To participate fully in developing you're counseling plan.
6. To expect that a licensed therapist has met minimal qualifications required by state law.
7. To examine public records maintained by the Oregon Board of Licensed Professional Counselors and Therapists and to have the Board confirm credentials of a licensee.
8. To report complaints to the Executive Board through either of the Co-Director(s) of Salem Pastoral Counseling Center, and/or to report complaints to the Oregon Board of Licensed Professional Counselors and Therapists.

You may contact the Board of Licensed Professional Counselors and Therapists at:

3218 Pringle Rd SE, #120, Salem, OR 97302-6312

Telephone: (503) 378-5499

Email: lpct.board@mhra.oregon.gov Website: www.oregon.gov/OBLPCT

For additional information about this counselor or therapist, consult the Board's website.

SALEM PASTORAL COUNSELING CENTER
CONFIDENTIAL INFORMATION SHEET

First Appointment Date_____ Counselor:_____

Client: Full Name _____

*** Appointment reminders will be sent to the email and cell ph# listed below.**

*** Cell Ph#**_____ Ok to Contact and leave message? **Please Initial Yes**____ **No**___

* I authorize SPCC to send information/correspondence via text message**.** **Please Initial Yes** ___ **No**___

*** E-Mail**_____ Ok to Contact by e-mail? **Please Initial Yes** ___ **No**___

Client Address _____ City _____ Zip _____

Ok to mail correspondence to this address? **Please Initial Yes** _____ **No** _____

Client Age_____ **Client Birth Date**_____**Social Security# (opt)** _____

Marital Status_____Occupation _____Employer _____

Emergency Contact:

Name_____ **Phone** _____ **Relationship**_____

Name/Address of person responsible for your payment (if not the client) _____
Names/Ages of Children_____

How did you hear about us? _____

<u>Person #2/Legal Guardian</u>: Full Name_____

Address_____**City**_____**Zip**_____

Ok to mail correspondence to this address? **Please Initial Yes**____ **No** ____

Cell Ph#_____ **Ok** to Contact and leave message? **Please Initial Yes**____ **No**____

I authorize SPCC to send information/correspondence via text message**.** **Please Initial Yes**____ **No**____

E-Mail_____Ok to Contact by e-mail? **Please Initial Yes**____ **No**____

Age_____ **Birth Date**_____ **Social Security#(opt)** _____

Marital Status_____**Occupation**_____**Employer**_____

Names/Ages of Children_____

SALEM PASTORAL COUNSELING CENTER
OFFICE POLICIES/INFORMED CONSENT

Prior to beginning treatment, it is important for you to familiarize yourself with your counselor's approach to treatment, your rights and responsibilities, and Salem Pastoral Counseling Center's (SPCC) office policies. This document, along with your counselor's Professional Disclosure Statement and our Notice of Privacy Practices, discusses these topics. Please take the time to review the information contained in these three documents and ask any questions you may have. After your questions and concerns have been answered, please sign and date on the reverse side of this page.

Approach to Treatment: To provide the best care possible, it is important that your counselor has a clear understanding of what brings you to treatment. In order to gain that understanding about your past and current functioning, a thorough assessment will be completed. Following the assessment, a treatment plan will be formulated and together with your counselor you will work towards the goals established. It is crucial that you are an active participant in therapy and candidly express with your counselor your treatment needs.

Risks and Alternatives to Treatment: It is important for you to know that there are risks involved in therapy. For example, some people experience an increase in stress particularly during the early stages of therapy. In some instances, discussing longstanding, unresolved problems can seem to aggravate rather than help with a problem. It is normal and understandable that it will be uncomfortable facing difficult feelings and situations. Keep in mind that, often, "the best way out is through", and your counselor will endeavor to walk through it with you. Your counselor may ask, "what will be different if counseling is successful for you?" You get to define that, and to a large degree are in charge of the pace and progress of your healing journey. If you or your counselor feel at any time that the professional relationship is not a good fit, your counselor will be willing to assist you in finding other options.

Appointments and Cancellations: Counselors work variable hours Monday through Friday with some evening appointments available. Counseling sessions are typically 45-55 minutes in duration. Please try to keep appointments you make, even if it is inconvenient. Appointments may be canceled or rescheduled by calling the voice mail of your counselor at 503-370-8050 and entering their extension. Because our counselors do their own scheduling, your counselor will contact you to reschedule. There is no charge for appointments canceled more than 24 hours in advance. However, except for genuine emergencies or illness, missed appointments and those canceled with fewer than 24 hours notice will be billed up to the usual fee ($165) for the time scheduled. Insurance companies will accept billing only for appointments actually kept, the client is billed directly the full amount for missed sessions.

Phone Calls and Emergencies: Salem Pastoral Counseling Center has a 24-hour/day, 7-day/week-voice mail system that can be reached by dialing 503-370-8050. All calls are routed through our confidential voice mail system. If you have a life-threatening emergency, please dial 911. If you are a current client and have an urgent situation, the on-call counselor can be reached by dialing 503-918-2180. A counselor will return your call as soon as they are able and will make effort to contact your specific counselor directly.

Confidentiality: Sessions are confidential with the following exceptions: (1) A report of suspected child abuse; (2) Threats to commit suicide; (3) Threats of violence against another person, (4) Abuse of elderly persons; (5) An acknowledged waiver of the privilege by the client; (6) By court order (7) When contacting a collection agency for nonpayment of fees. Written permission from you is necessary in order for your counselor to release information to another person. Please refer to our Notice of Privacy Practices for a more complete outline of how your confidential information is handled.

Communications and Your Privacy: Please know that despite all security efforts, email, cell phone including text messages, and fax communication can be relatively easily accessed by unauthorized people, which can compromise the privacy and confidentiality of such communication. If you convey sensitive personal information by cell phone, email, or fax, your counselor and SPCC assumes that you have made an informed decision accepting this risk. To protect your privacy, we strongly suggest communicating sensitive information in person or on your counselor's confidential voice mail and limiting email or cell phone communication to scheduling issues only. Please also understand that any requests for contact related to social networking will not be confirmed or acknowledged to protect your privacy.

Legal Issues: ALL COUNSELORS of Salem Pastoral Counseling Center are unwilling and unavailable to testify or advocate in legal situations, disability determination and custody studies. If you need a court evaluation, testimony in court, or any legal support, your counselor will assist you in finding someone who can provide those services.

Insurance: Please review your insurance policy for coverage of outpatient mental health services. Sometimes insurance companies will require pre-authorization and it is your responsibility to obtain this prior to treatment or the insurance will not pay. SPCC will file insurance claims for you, however, this is a courtesy on our part. You are personally responsible for the entire insurance process. We cannot guarantee that the insurance company will reimburse and it is important to understand that you, as the client, remain responsible for whatever portion of the bill your insurance company does not pay. Should there be an overpayment, we will refund the difference either to you or your insurance company, depending on who has overpaid.

Payment and Billing: You are expected to pay your fee or co-pay at each office visit unless other arrangements are made in advance. Our first session intake fee is $195.00 and all subsequent fees are $165.00 per session. All balances past due 60 days will be assessed a monthly 1.5% finance charge.

Adjusted Fee Schedule An income-dependent adjusted fee schedule is also available for those **without insurance**. If you believe you may qualify for the **adjusted fee schedule** (and are willing to provide documentation upon request) please complete the following:

1) Total family gross monthly income: _____

(Include all income before taxes, including child support, spousal support, school grants, and state-assistance programs.)

2) Number of persons this income supports: _____

Please keep your counselor informed of any changes in your financial status, as an increase or decrease of income will affect your adjusted fee.

Additional office information: (to be entered by therapist): _____

If you have any questions, please don't hesitate to ask your counselor or the office staff.

Consent to Treatment: I have read the above information and have had the opportunity to ask questions about it. I understand my rights to privacy and the risks associated with treatment. If there are children involved in treatment, I hereby give consent for their treatment and affirm that I am the legal guardian with the authority to consent to treatment. I also agree to the payment and billing policies outlined above and accept full responsibility for any and all fees incurred. I consent to participate in treatment and I understand that I may refuse services at any time. I hereby authorize the Salem Pastoral Counseling Center to provide all information necessary to process all insurance claims. I am also aware that my counselor may periodically consult with other counselors at SPCC and/or with clinical supervisors on client issues. **My signature below indicates I have received a copy of my therapist's Professional Disclosure Statement, Notice of Privacy Practices, and have read, understand and agree to abide with the policies outlined on both sides of this document, and have obtained copies of these documents for future reference.**

1)_____
Client (Legal Guardian) Signature

_____
Date

2)_____
Client (Legal Guardian) Signature

_____
Date

SALEM PASTORAL COUNSELING CENTER
CONFIDENTIAL PERSONAL HISTORY FORM

In order to help us provide the best care, please complete this form. If you are not sure about any item, or feel uncomfortable answering, please leave that part blank. Answer what you are able, and speak with your counselor about any areas of concern.

Client information:

Today's date _____ Counselor's Name_____

Client full name _____Date of birth _____

Church Affiliation_____

Please describe your reasons for seeking counseling:

_____

_____

_____

_____

What do you want to accomplish as a result of your counseling here?

_____

_____

_____

Current Situation:

Relationship status: Married ☐ Separated ☐ Divorced ☐ Single ☐

Long term relationship ☐ How long? _____

If in a committed relationship, how would you describe your relationship?

_____

_____

Children: Names and Ages_____

_____

How would you describe your relationship with your children? _____

_____

Other people living with you: names and relationship

_____

_____

Areas of concerns: please check all that apply:

Emotional issues	**current problem**	**problem in past**	**no problem**
anxiety (worry, fear, excessive guilt)			
depression (unhappiness, lack of energy, drive)			
thinking problems (disorganized, confused, unable to focus)			
uncontrolled repetition in thinking and/or behavior			
mood swings (change quickly, hard to control, feeling "numb")			
anger (hard to control, inappropriate anger, resentment)			
grief (feelings of loss, sadness, crying)			
suicidal thinking or action			
nightmares/sleep disturbances			
withdrawn/few friends			
panic attacks			
nervous or repetitive habits			
Behavioral issues			
employment			
legal problems			
gambling			
stealing			
lying			
sexual problems			
obsessions/compulsions			
problems with attention			
eating problems			
learning problems			
pornography			
Alcohol and/or Drugs			
Tobacco			
Setting Fires			
Trauma and/or Abuse			

Have you been in therapy before? No ☐ Yes☐

Counselor's name _____ when ?_____

Counselor's name _____ when ?_____

Have you ever been hospitalized for psychiatric problems? No ☐ Yes☐

If so, when? _____

Medical background:
Name of primary care physician_____

Are you currently under medical care? _____ Please describe_____

_____

Are you currently on prescription medication? _____ Please describe_____

_____

Do you take over-the-counter medicine? _____ Please describe_____

_____

Have you ever had a head injury? No_____ Yes_____ If so, when_____

List any serious medical concerns you are having currently or any medical conditions you've had in the past._____

_____

_____

Family History:

Parent Information	Mother	Father
Alive or deceased?		
Age		
If alive where do they now live?		
Use of alcohol/other drugs now or in the past		
Abusive to you or other family members? (physically, sexually, mentally, spiritually)		
History of mental illness in the family?		
Medical problems? If so what?		

Siblings: names and ages _____

_____

Are you adopted? _____Your highest level of school completed_____

How would you describe your family when you were a child (example: how parents got along, were they available to you, significant problems, finances, etc.) _____

_____

_____

_____

How would you describe your current relationships with your family of origin?

_____

_____

_____

_____

_____

Social History:

Describe briefly where you receive emotional or social support (example: church, social events, family, work, hobbies, clubs?) _____

_____

Describe briefly your history of making and keeping friends (easy? difficult? many friends? a few close friends? No friends?)

_____

_____

_____

_____

Additional Information:

Is there any other information you think would be helpful for me to know?

_____

_____

_____

_____

_____

_____

_____

_____

SALEM PASTORAL COUNSELING CENTER
AUTHORIZATION FOR INSURANCE BILLING

Counselor:_____ Client:_____

Please check with your insurance company prior to receiving services to answer the following questions:

$_____Deductible Amount- How much of your deductible have you met for the current year? $_____
$_____CoPay Amount
_____Does your insurance require pre-authorization? Authorization Number _____
_____ Anniversary date of Coverage
_____ Copy of insurance card has been (or will be) provided (copy of card is preferred)
_____ Will payments for services be issued directly from a health spending account?

(Fill out the following ONLY if copy of card is NOT provided.)

Client's Primary Insurance Company _____

ID#_____Group#_____

Subscriber (Name on policy) _____ Subscriber DOB _____

Subscriber Employer _____

Client's Secondary Insurance Company _____

ID#_____Group#_____

Subscriber (Name on policy) _____ Subscriber DOB _____

Subscriber Employer _____

I authorize that the above information is accurate and true to the best of my knowledge. I authorize my insurance company to pay Salem Pastoral Counseling Center directly for services rendered according to my mental health coverage. I authorize Salem Pastoral Counseling to provide all information my insurance company(ies) request(s) concerning my treatment. I understand that I am responsible for pre-authorization or doctor's referral if required. I understand that I am financially responsible for services performed whether or not paid by insurance. I understand that any money received in excess of my charges will be refunded when my bill is paid in full. **I understand I am responsible for full payment for any missed sessions, or sessions canceled without 24 hour notice.**

Signature of client or responsible party_____

SALEM PASTORAL COUNSELING CENTER
AUTHORIZATION FOR THIRD PARTY BILLING
(Non-Insurance)

Client Name _____

Counselor Name _____

I hereby authorize the Salem Pastoral Counseling Center to bill the company, agency, organization, or person(s) listed below for sessions I or my family member have attended at the Center.

Send Bills To _____

_____

_____

Limits of Billing _____

_____

_____

I understand I am responsible for full payment for any missed sessions, sessions canceled without 24 hours notice, or any payments refused by third party payer.

Client Signature _____ Date _____

Salem Pastoral Counseling Center

2001 Commercial St. SE Suite 200 Salem, OR 97302
Telephone 503-370-8050 Fax 503-370-9982

AUTHORIZATION TO DISCLOSE RECORDS

I authorize _____ to release a copy
(Name of person releasing records)
of the applicable information for _____ _____
(Name of client) (Date of birth)
to_____
(Name and address of recipient)

_____

The information will be used on my behalf for the following purpose(s):
_____

_____

By **initialing** the spaces below, I specifically authorize the release of the following records, if such records exist:

_____Mental health records
_____Medical records needed for continuity of care
_____Drug/alcohol evaluation and/or treatment
_____Employment records
_____Most recent five-year history
_____Other _____
_____School records
_____Summary letter
_____Progress notes
_____Billing statements
_____History/evaluation

_____Please send the entire record (all information) to the above named recipient. The undersigned understands these records may be voluminous and agrees to pay all reasonable charges associated with providing these records.

_____This authorization is limited to the following treatment:
_____

_____This authorization is limited to the following time period:
_____

_____This authorization is limited to a workers' compensation claim for injuries of _____ (Date).

I agree that the agencies and individuals listed above may share and **exchange** information about my circumstances. Initial one: _____yes _____no

(Please complete both sides of this release)

_____

(Print name of client)

****NOTICE** Records can only be released if all parties in attendance of the sessions have signed this authorization.**

I can cancel this authorization for release at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so. Unless revoked earlier, in writing, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request.

_____

(Date) (Signature of client)

_____

(Date) (Signature of client)

_____ _____

(Date) (Signature of person authorized by law)

NOTICE TO RECIPIENT OF INFORMATION: This information has been disclosed from records which are confidential. Any further disclosure without the specific written consent of the person to whom it pertains exceeds the limits of this release, is prohibited, and may carry penalties.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how Salem Pastoral Counseling Center (SPCC) may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

Our Obligations

SPCC is required by State and Federal law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. SPCC is required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. SPCC will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

Uses and Disclosure. SPCC may use and disclose protected health information without your consent in the following ways.

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications;

(iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at _____:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at _____ or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.