Dare 2 Hope Counseling
Cherie Miller, MS, LPC

Dare 2 Hope Counseling
578 N Kimball Ave., St.150
Southlake, TX 76092

PROFESSIONAL DISCLOSURE AND STATEMENT OF CLIENT RIGHTS

Welcome! It is my desire to assist you in making informed decisions about your treatment. As a client of psychotherapy and as a consumer, you have certain rights. Therefore, I will explain the information you are entitled to know, such as my view of the therapeutic process, and my expectations for the cooperative working agreement. Please feel free to ask questions about any of the following information.

MY CREDENTIALS

I'm a Licensed Professional Counselor in the State of Texas. I have a Masters of Counseling degree from Grand Canyon University (2016), and have a Bachelors of Art in English with a minor in Psychology from Abilene Christian University (2004). I have over 10 years of experience as an eating disorder mentor, speaker, educator, and advocate. I am also a member of the International Association of Eating Disorders Professionals Foundation (iaedp), Texas Counseling Association (TCA), and the American Association of Christian Counselors Association (AACC).

THE THERAPEUTIC PROCESS

Counseling has both benefits and risks. Benefits for people who undertake counseling often include a reduction in feelings of distress, more satisfying relationships, increased clarity and resolution of specific problems. Growth nearly always brings change, and sometimes change (even positive change) causes stress. Potential risks of counseling involve recalling unpleasant aspects of your personal history that may bring up distressing thoughts and feelings. Every effort will be made to assist you to reach your therapeutic goals. If you have any concerns about your progress or the results of your counseling experience, please talk with me at any time during our work together.

As you talk about your thoughts, feelings, and experiences, we will work together as partners to gain the understanding and insight necessary for change to occur. Any goals for counseling and/or decisions you make to facilitate change are ultimately up to you. Some clients need only a few counseling sessions to achieve their goals; others may require months or even years of counseling. As a client, you may end our counseling relationship at any time without any additional moral, legal, or financial obligation, though I do ask you participate in a termination session. At any time, either you or I may initiate discussion of possible positive or negative effects of continuing or not continuing counseling, and/or using or not using certain techniques. You have the right to ask any questions about the procedures used during therapy. If you wish, I shall explain all therapeutic procedures and their rationales to you.

THE COUNSELING RELATIONSHIP

Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to counseling sessions you arrange with me. In the event of an emergency, you may contact 240 Counseling by phone. Due to ethical guidelines, I ask that you do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling sessions. You will best be served if our sessions concentrate exclusively on your concerns. My services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible for me to guarantee you any specific results regarding your counseling goals. However, together we will work to achieve the best possible results for you.

CONFIDENTIALITY

No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Texas law. You, as a client, may revoke your consent to treatment, release

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of confidential information, or disclosure in writing at any time during psychotherapy. The information you discuss during a psychotherapy session is protected as confidential under law with certain limitations:

- It is my policy to report suspected child abuse without an investigation to the proper authorities who may then investigate.
- I also may take some action, such as seek an order for your emergency or involuntary commitment, without your consent if I deem you to be a serious harm to yourself or another. Any action I take without your consent will be discussed with you.
- It is my duty, under Texas statute to warn any individual in imminent danger of harm by you, as well as to report the danger to authorities.
- If I am unable to collect my agreed upon fee, I may send your name and address to a collection agency.
- If you file an official complaint or a lawsuit against me, according to Texas law, your right to confidentiality will be waived.
- If I seek consultation from another mental health professional, your privacy will be protected by that professional. I will reveal only the necessary private information for the purpose of the consultation.
- If another mental health professional is involved in your mental health treatment and I determine that it is important for your treatment, I may collaborate in order to coordinate care. You will need to sign a consent to release form, which can be obtained from me or my website at www.dare2hopecounseling.com.

The full explanation of your confidentiality rights is outlined in the document "Notice of Privacy Practices." If you have any questions about confidentiality, please review that document and/or ask me.

I have read and understand the Notice of Privacy Practices.	**Client or Guardian Initials _____**

As a client, I understand that text, email, voicemail and phone are not secure lines of communication. Dare 2 Hope Counseling will not be held liable for miscommunication, or any breach in confidentiality associated with these methods of communication.

EMERGENCIES

My practice is not prepared to handle emergencies, so please either dial 911 or go to your nearest Emergency room. Once you have either called 911 or gone to the emergency room, please leave me a voice mail indicating you have done so. When signing you understand your psychotherapist(s) provides non-emergency psychotherapeutic services by scheduled appointment. If my psychotherapist(s) believe(s) my psychotherapeutic issues are above her or his level of competence, or outside of his or her scope of practice, he or she is legally required to refer, terminate, or consult.

OTHER IMPORTANT INFORMATION:

I understand that in marriage and family counseling, my therapist holds a "NO SECRETS" policy. All members of the couple or family system are treated equally and "secrets" are not kept by the therapist that require differential or discriminatory treatment of family members. Signing this disclosure statement affirms permission to share this confidential information.

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COMPLAINTS

You have the right to decide not to receive psychotherapy from me. If you wish, I shall provide you with the names of other qualified therapists. A verbal exploration of alternatives to counseling will also be made upon request. If at any time you are dissatisfied with my services, please let me know. If I am not about to resolve your concerns, you also have the right to address any complaints against licensed professional counselors to the Texas State Board of Examiners of.5540.

I have read the preceding information, and I understand my rights as a client or as the client's responsible party. I understand that I have any questions or would like additional information; I may ask at any time.

_____
Print Client's Name

_____
Print Parent/Guardian Name

_____ _____
Signature of parent/guardian Date

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Personal History (Minors)

Please complete this form as thoroughly as possible.

General Information

Client's First and Last Name: _____ Date: ____/____/_____

Date of Birth: ____/____/_____ Age: _____

Form Completed By (if someone other than client): _____Relationship: _____

Street Address: _____ City: _____ Zip: _____

Preferred Phone (parent): _____ Which do you consent to receive: □ Texts □ Voicemail

Email Address, if you consent to receive emails (parent):_____

School: _____ Grade Level: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Relationship to Client: _____

Health Information

List all past or present significant illnesses, injuries, or disabilities: _____

_____

List any recent health changes: _____

Are you currently or have you recently used recreational drugs (within last 12 months): □ No □ Yes

Do you drink alcohol? □ No □ Yes If yes, _____ times per _____ (week or month)

Do you use tobacco? □ No □ Yes If yes, _____ times per _____ (week or month)

Physician's Name: _____ Last physical exam or doctor's visit: ____/____/_____

If anything out of the norm was discovered, please describe: _____

Family Information

Parent's Marital Status: □ Married □ Divorced

Please indicate who lives with you at this time (if parents have joint custody, please fill out for both houses):

Name	Relationship to You	Age	Gender

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CHILDHOOD DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development?

□ No □ Yes If yes, please explain _____

_____

Has there been history of abuse? □ No □ Yes If Yes, which type(s)? □ Sexual □ Physical □ Emotional/Verbal

If Yes, the abuse was as a: □ Victim □ Perpetrator

Other childhood issues: □ Emotional neglect □ Physical neglect □ Other (please specify): _____

Special circumstances (e.g., raised by person other than parents, etc.): _____

Anything else your therapist should know about your childhood development: _____

_____

RELIGIOUS BACKGROUND

How important to you are spiritual matters? □ Not □ A Little □ Moderate □ Very Much

Are you affiliated with a spiritual or religious group? □ No □ Yes If yes, please list:_____

Do you attend a place of worship? □ No □ Yes If yes, church attended: _____

Describe any recent changes in spiritual life, if any: _____

_____

CULTURAL/ETHNIC

To which ethnic group do you belong?

□ African-American □ Anglo □ Hispanic □ Native-American □ Other:_____

Are you experiencing any problems due to cultural or ethnic issues? □ No □ Yes If yes, please explain: _____

_____

Cultural/ethnic information you would like your therapist to know: _____

_____

PSYCHOLOGICAL AND MEDICAL TREATMENT

Current prescribed medications	Dose	Started	Purpose	Side effects (if any)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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Current over the counter meds	Dose	Started	Purpose	Side effects (if any)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Psychiatrist's Name (if applicable): _____ Last visit: ____/____/_____

If you have previously been to a therapist or been in a treatment facility, please indicate below.

Therapist or Facility Name	Dates	Reason for Treatment	Comments (optional)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you exercise? □ No □ Yes If yes, briefly describe your exercise routine: _____

Check any of the following areas with which you currently experience issues. Circle your top three areas of concern.

___Abortion	___Divorce	___Loss of appetite	___Religion/faith Issues
___Abandonment issues	___Drug abuse	___Loss of control	___Same-sex attraction
___Adoption	___Eating disorder	___Loss of concentration	___Self-injury/self-harm
___Addictions	___Envy /Jealousy	___Loss of energy	___Separation
___Alcohol abuse	___Family issues	___Loss of memory	___Sexual abuse/Rape
___Anger	___Father issues	___Loss of sleep	___Sexual addiction
___Anxiety	___Fear of rejection	___Loss of temper	___Sexual compulsion
___Apathy	___Fear (general)	___Loss of trust	___Sexual issues (other)
___Bitterness/Resentment	___Finances/Debt	___Marriage	___Single parenting
___Burnout/Stress	___Forgiveness	___Medication/Drug	___Singleness
___Change of lifestyle	___Frustration	Issues	___Spouse abuse
___Child abuse	___Gambling	___Mid-life	___Substance abuse
___Children/discipline	___Guilt	___Mother issues	___Suicidal thoughts
___Children/school	___Health/Medical	___Obsessive	___Self-esteem
___Children/rebellion	___Honesty	thoughts/actions	___Rejection
___Communication	___Infidelity	___Panic attacks	___Violence/Rage
___Confusion	___In-Laws	___Physical abuse	___Withdrawal
___Crisis/Conflict	___Job problems	___Pornography use	___Worry
___Death of loved one	___Legal issues	___PMS/Hormones	___ Other (list below)
___Depression	___Loneliness		

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Briefly describe the problem or concern that brings you here today and when it began: _____

_____

Have you or anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	**Self?**	**List Family Member (if applicable)**
Depression	□	
Bipolar disorder	□	
Anxiety disorder	□	
Panic attacks	□	
Schizophrenia	□	
Alcohol/substance abuse	□	
Eating disorders	□	
Learning disabilities	□	
Trauma history	□	
Suicide attempts	□	
Chronic illness	□	

Have you ever experienced a severe emotional upset? □ No □ Yes If yes, please explain _____

_____

_____

Please indicate how you found Dare 2 Hope / Cherie Miller, MS, LPC:

□ Referral (name): _____

□ Google search

□ Psychology Today website

□ Church (name): _____

□ I'm a returning client

□ Other (please describe): _____

All of the above information is true and correct to the best of my knowledge.

_____ _____
Signature of client **Date**

_____ _____
Signature of parent/guardian **Date**

For Staff Use

Therapist's signature: _____ Date: ___/___/____

Physical exam: □ Recommended □ Not recommended at this time

Therapist comments: _____

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FINANCIAL CONSENTS (to be completed by guardian)

FEES AND PAYMENTS

- My rate is $150 per 50-minute session. I do offer a sliding scale based on income as follows. Please indicate the income range of your household to establish which fee you will be charged per session. If you are on a discounted rate and at any point, your income changes, you are obligated to inform me of your updated financial status. If your status changes, you will possibly be charged a different fee.

□ $74,999 or less {$100/session}	□ $75,000 to $99,999 {$125/session}	□ $100,000 or higher {$150/session}

- All fees are due at the beginning of each session unless you are enrolled in automatic payments or other arrangements have been made in advance. I accept payment by exact cash or check (made out to Cherie Miller, MS, LPC). Appointments for additional sessions might be declined or cancelled if you have an unpaid balance. If you have any questions concerning your account, please contact me.
- The standard and customary fee for a session (a session is 50 minutes from start to finish) is $150.00. However, reduced fees based on gross annual income are available for those in need of financial assistance. Our sliding scale fee is subject to change at any time and fees may be changed during the course of our therapy. If your session fee will be changing, you will be given four weeks' notice prior to the change taking effect.
- If a check is returned, a fee of $25.00 will be assessed to your account. Additionally, you will need to make a cash or credit card payment for the amount of the returned check as well as the $25.00 processing fee. I might require cash payment for future appointments if I receive a returned check from you.
- Failure to pay will be a cause for termination of psychotherapy services.

LATE CANCELLATIONS/NO SHOWS/LATE TO SESSION

- There will be a fee equal to the amount of your regular session fee in the event of a late cancellation or no show. A "late cancellation" is defined as canceling within the 24-hour period prior to your appointment. A "no show" is defined as failing to attend an appointment without prior notice.
- If you are late to a session, your session will end at its scheduled time, and you will be charged the normal fee.

INSURANCE

- I do not accept insurance but can provide a receipt, or superbill, for you to submit to your insurance company for possible reimbursement of part of the session fee. It is your responsibility to find out from your insurance company how much, if any, reimbursement would be provided. It is also your responsibility to submit the receipt directly to your insurance provider.

TELEPHONE AND EMAIL CONSULTATIONS

- On occasion, it is necessary for a client to contact the counselor by telephone outside of the regular therapy session to discuss an issue. Any phone calls over 5 minutes will be prorated at your regular rate.
- If your counselor agrees to email consultations, you will be billed at your regular rate, prorated for the amount of time it takes to read and respond to your email. An itemized statement would be available upon request.

I have read, understand, and agree to the payment information as stated above.

_____ _____

Signature of parent/guardian **Date**

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PRE-AUTHORIZED CREDIT CARD PAYMENT FORM

(to be completed by guardian)

Please complete the following information. This form will be securely stored in your file and may be updated upon request at any time. This is your consent to make payment for services rendered via credit/debit card.

I,_____, hereby authorize Dare 2 Hope Counseling / Cherie Miller, MS, LPC to bill my credit card at the agreed upon fee for professional services including all of the following:

- Appointments I elect to pay for by credit card
- Missed appointments (no shows or not cancelling within 24 hours of appointment)
- Balances for charges not paid within 90 days
- Returned checks (amount of check + $25.00)

Please initial one of the following:

_____ I authorize automatic payment of sessions on this card so that I do not have to spend session time making payments.

_____ I do not authorize automatic payment and will make payment at the beginning of each session.

CARD INFORMATION

Cardholder Name _____ Phone _____

Billing Street Address _____ City, State, Zip _____

□ Visa □ MasterCard □ Discover □ American Express

Account Number _____

Expiration Date _____

CVV (3-digit number on back of Visa/MC, 4 digits on front of AMEX) _____

I authorize Dare 2 Hope Counseling / Cherie Miller, MS, LPC to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

I have read, understand, and agree to the payment information as stated above.

_____ _____

Signature of parent/guardian **Date**

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Policies Regarding Court, Depositions, Subpoenas, and Any Other Legal Matter (to be completed by guardian)

Cherie Miller, MS, LPC is not trained for any type of court work, is not trained to advise on legal matters, and cannot evaluate cases for custody. Nor is Cherie Miller, MS, LPC trained to be expert witnesses in any matter.

I understand that if I am involved in any legal action that requires testimony or deposition, that Dare 2 Hope Counseling / Cherie Miller, MS, LPC will charge a fee of $300.00 per hour portal to portal. This fee also includes time spent preparing for the testimony or deposition, legal fees incurred by Cherie Miller, MS, LPC, and making copies of any records involved. I understand that I am responsible for this fee even if it is the opposing attorney requesting records, deposition, testimony, or other services. A $1,500.00 deposit is due within two (2) business days of my receiving notice from Dare 2 Hope Counseling / Cherie Miller, MS, LPC that she has received the subpoena, notice of deposition, or other request concerning judicial activity. Should the subpoena require Cherie Miller, MS, LPC to be present for court, deposition, or other judicial activity in less than 48 hours, the $1,500.00 deposit is due immediately upon my receiving notice from Dare 2 Hope Counseling / Cherie Miller, MS, LPC that they have received such subpoena or other notice and an additional fee of $500.00 will be charged in addition to the regular hourly fee of $300.00, due to the need of the counselor to alter his/her patient schedule on such short notice.

Requests for records in any legal matter pertaining to a minor will require either the signature of a custodial parent or a court order from the judge for me to release any records.

I have read, understand, and agree to the payment information as stated above.

_____ _____

Signature of parent/guardian **Date**

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PERMISSION TO RENDER PROFESSIONAL SERVICES TO A MINOR

(to be completed by guardian)

In all divorce and legal separation circumstances, we must have a copy of the divorce decree or separation agreement indicating which parent has the legal authority to make counseling decisions for your minor child before we can meet with the child.

I attest that I have the legal authority to seek and grant permission for professional services for the minor child named in this intake application.

_____
Print Parent/Guardian Name

_____
Relationship to minor

_____ _____
Signature of parent/guardian Date

_____
Print Parent/Guardian Name

_____
Relationship to minor

_____ _____
Signature of parent/guardian Date

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NOTICE OF PRIVACY PRACTICES (For Client to Review and Keep)

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. ANY REFERENCES IN THIS DOCUMENT TO MEDICAL PRACTICE, MEDICAL RECORDS, MEDICAL SERVICES, ETC., APPLY ALSO TO PSYCHOTHERAPY .

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart, on a computer, and/or in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay you. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your voice mail or in a message left with the person answering the phone.
5. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
6. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
7. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
8. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
9. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
10. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
11. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
12. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
13. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
14. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
15. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.
16. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
17. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint by using the form from the website below:

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.