Informed Consent

Patricia Clemmons M.Ed LPC #62215

Licensed Professional Counselor

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Date:_____

Name:_____

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and note any questions you might have so you can discuss them with me during your intake. Once you sign this consent form, it will constitute an agreement between us.

Qualifications

I earned a Master of Education at Texas Tech University. I hold license number 62215 as a Licensed Professional Counselor with the state board of examiners for licensed professional counselors. An individual who wishes to file a complaint against a Licensed Professional Counselor may write to:
Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369

Nature of Counseling Services

Psychotherapy is the process where mental health distresses and disorders are assessed, prevented, evaluated, and treated. There are a variety of techniques that can be utilized to deal with the problem(s) that brought you or your child to therapy. These services are generally unlike any services you may receive from a physician in that they require your active participation and cooperation.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your or your child's life, you or they may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, better problem-solving and coping skills, and significant reductions in feelings of distress. Given the nature of psychotherapy, it is difficult to predict what exactly will happen. No guarantees can be made regarding outcomes or regarding what you will experience.

Procedures

Our first few sessions will involve an evaluation of you or your child's needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one hour session (one appointment hour of 30 to 60 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation, unless we both agree that you were unable to attend due to circumstances beyond your control. If it is possible, I will try to find another time to reschedule the appointment.

The overall length of psychotherapy (in weeks or months) is generally difficult to predict but is something we can discuss when the initial treatment plan is reviewed with you after the evaluation.

Professional Fees

My basic hourly fee is $75. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time. Because of the difficulty of legal involvement, I charge $100 per hour for preparation and attendance at any legal proceeding. This is not applicable to children who are in CPS custody. Foster parents will not be expected to provide payment for my participation in legal proceedings unless foster parents have retained an attorney who issues a subpoena to me.

_____Please initial here to indicate you have read and understand this part of the agreement.

Billing and Payments

With the exception of Texas Medicaid, Superior, Blue Cross Blue Shield, and First Care, I am not a provider for any other insurance companies.

You will be expected to pay for each session at the time it is held. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

If you are on a high deductible insurance plan, you will be expected to pay for services until your deductible is met.

Your specific hourly fee will be _____ per _____minute session.

_____Please initial here to indicate you have read and understand this part of the agreement.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for counseling services yourself without involving your insurer for reimbursement of what you have paid.

Contacting Me

I am often not immediately available by telephone. While I am usually in my office between 9:30 AM and 5:30 PM, I probably will not answer the phone when I am with a client. I have extended hours to accommodate clients when able, but these are only as scheduled. When I am unavailable, you may leave a message on my voicemail, which is on a cell phone only used by me. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

I prefer using email only to arrange or modify appointments if phone contact is not possible. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet Service Providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet Service Providers. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

Professional Records

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, unless I believe that seeing them would be emotionally damaging to you. If this is the case, I will be happy to provide your records to an appropriate mental health professional of your choice. Although you are entitle to receive a copy of your records if you wish to see them, I may prefer to prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests. There is a fee if you request a copy of records for yourself or if an attorney representing you or your child requests records for a court proceeding. I will provide a copy of your records for 20 cents per page.

If you are under 18 years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is policy to request an agreement from parents that they consent to give up full access to your records. If they agree, I will provide your parents only general information on how your treatment is proceeding unless there is a high risk that you will seriously harm yourself or another person. In such instances, I may be required by law to notify your parents of my concern. Parents of minors also can request to be provided with a summary of their child's treatment when it is complete. Before giving your parents any information, I will discuss this matter with you, if possible, and will do the best I can to resolve any objections you may have about what will be discussed. Please note that I do not provide treatment of minors without their parents' consents except when permitted by law.

The state of Texas requires that I keep your records for 7 years after termination of counseling services and for minors, 7 years after the minor turns 18 years old.

Confidentiality

In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with your written permission. However, there are a few exceptions:

- Client requests release of information
- Court orders a release of information
- Client initiates a malpractice lawsuit
- Client is below 18 years of age, parents have rights to therapeutic information
- A child is abused or neglected
- An elderly person is abused or neglected
- A disabled person is abused or neglected
- Client is a danger to self/others
- An insurance company or managed care company requests a diagnosis and/or relevant clinical information

One additional situation that would necessitate disclosure of information is in the case of involvement of Texas Child Protective Services (CPS) in your case. **If they are the legal Managing Conservator of a minor with whom I meet for sessions, they are legally the parent and are allowed access to the files.** Typically they only require summaries of progress. These summaries are provided to the Child Placing Agency with whom the child is placed and are then in turn shared with CPS. By signing this disclosure you understand that I am obligated to provide reports to CPS on a monthly basis should you or your child be involved with CPS.

_____Please initial here to indicate you have read and understand this part of the agreement.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I suspect that a child, elderly person, or disabled person is being abused or neglected, I may be required to file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to

keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Physical Health

Psychological disorders and symptoms often have a strong correlation with medical illnesses. At times, some medical conditions require a medical differential diagnosis to determine symptom etiology. If your presenting symptoms are organic in origin, it is critical that you obtain medical treatment. Therefore, if you have not had a physical in the last six months, it is recommended that you do so. In addition, prescription and non-prescription medications may have significant side effects that may be important for us to consider. I expect full disclosure of all medicines and drug and alcohol intake and may request a Release of Information so that I can coordinate therapeutic services with your physician if appropriate.

Transfer Plan

In the event that I become incapacitated in some way or unexpectedly die, and am unable to continue providing services for you, I have designated Dana Divine, Licensed Professional Counselor to access my files. She can be contacted at 806-790-5405. Ms. Divine will assist you by continuing therapy services with you if possible or assisting you to access your files and transfer them to another mental health professional of your choice. This will be true whether the situation is temporary or permanent. Once she is informed of my incapacitation or death, she will begin contacting my clients. However, if you find yourself unexpectedly unable to contact me, you may contact her to facilitate continued services. She will maintain confidentiality of your file and information just as I would and is bound by the same ethical codes that I am.

Signature(s)

If you have questions or concerns about any of these policies and procedures, do bring them to my attention so that we can discuss them.

Your signature below indicates that you have read the information in this document, that you have understood it, and that you agree to abide by its terms as long as you are a client of this practice.

Client Signature_____ Date_____

Parent/Guardian Signature_____ Date_____
(If client under age 18)

Witness Signature_____ Date_____

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, other clients and therapists inside our office) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. By signing the document you indicate that you understand and agree to these actions for yourself and for your child:

- You will only keep your in-person appointment if you are symptom free.
- You will take your/your child's temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee (not applicable to Medicaid billing).
- You will arrive no earlier than 5 minutes before our appointment time.
- You will follow our waiting room capacity of 3 people in the waiting room at a time.
- You will wait in the hallways or other waiting rooms in the building, in your car, or outside if the waiting room is at capacity.
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- You will adhere to the safe distancing in the waiting room and therapy room.
- If you have a job that exposes you to other people who are infected, you will immediately let me know.
- If a resident of your home tests positive for the infection, you will immediately let me know and we will then [begin] resume treatment via telehealth.

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office (practices attached). We are practicing additional cleaning and sanitizing of toys between each sessions. Masks and hand sanitizer

Before the beginning of each session, I will ask you if you would like for me to wear a mask during session with your child. If you do not indicate that you want me to wear a mask, I will do so at my discretion. I will not require your child to wear a mask during session; however, if you prefer that your child wears a mask, they are welcome to do so. Masks may be provided at the office or you are able to bring your own. I am able to use social distancing in sessions.

If You or I Are Sick

You understand that I am committed to keeping you, me, the other therapists and all of our families safe from the spread of this virus. If you show up for an appointment and I believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I or another therapist test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____

Cleint's printed name Date

_____ _____

Signature of adult caregiver Relationship to client

Office Safety Precautions in Effect During the Pandemic

My practice is taking the following precautions to protect our clients.

- Office seating in therapy rooms I utilize has been arranged for appropriate physical distancing.
- Therapists maintain safe distancing.
- Restroom soap dispensers are maintained and everyone is encouraged to wash their hands.
- Hand sanitizer that contains at least 60% alcohol is available in the therapy rooms and the waiting room
- We will attempt to schedule appointments at varying intervals to minimize the number of people in the waiting room and to properly disinfect therapy rooms between clients.
- We ask all clients to observe the waiting room to 3 individuals at a time or to wait in their cars or outside. Please only allow one guardian per child to wait in the waiting room.
- We ask that you limit adults accompanying a child or dependent client to 1. Other guardians or family members are welcome to wait in the other areas of the building or in your vehicle. If necessary, I will come to the car to retrieve and/or return your child before/after session.
- We ask all clients to arrive until no earlier than 5 minutes before their appointment times.
- Areas that are commonly touched are thoroughly disinfected after each use.
- Physical contact is not permitted.
- Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
- Common areas are scheduled to be disinfected throughout the day.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. YOU MAY HAVE ADDITIONAL RIGHTS UNDER STATE AND LOCAL LAW. PLEASE SEEK LEGAL COUNSEL FROM AN ATTORNEY LICENSED IN YOUR STATE IF YOU HAVE QUESTIONS REGARDING YOUR RIGHTS TO HEALTH CARE INFORMATION.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (hereafter, "HIPAA"), you have certain rights regarding the use and disclosure of your protected health information (hereafter, "PHI").

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information.

I am required by law to:

- Make sure that PHI that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all the information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your PHI for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your PHI, which is otherwise confidential, in order to

assist the clinician in diagnosis and treatment of your health condition. I may also use your PHI for operations purposes, including sending you appointment reminders, billing invoices and other documentation.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about you or your minor child(ren) in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. **Psychotherapy Notes.** I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
    a. For my use in treating you.
    b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
    c. For my use in defending myself in legal proceedings instituted by you.
    d. For use by the Secretary of the Department of Health and Human Services (HHS) to investigate my compliance with HIPAA.
    e. Required by law and the use or disclosure is limited to the requirements of such law.
    f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
    g. Required by a coroner who is performing duties authorized by law.
    h. Required to help avert a serious threat to the health and safety of others.
2. **Marketing Purposes.** I will not use or disclose your PHI for marketing purposes without your prior written consent. For example, if I request a review from you and plan to share the review publically online or elsewhere to advertise my services or my practice, I will provide you with a release form and HIPAA authorization. The HIPAA authorization is required in the instance that your review contains PHI (i.e., your name, the date of the service you received, the kind of treatment you are seeking or other personal health details). Because you may not realize which information you provide is considered "PHI," I will send you a HIPAA authorization and request your signature regardless of the content of your review. Once you complete the HIPAA authorization, I will have the legal right to use your review for advertising and marketing purposes, even if it contains PHI. You may withdraw this consent at any time by submitting a written request to me via the email address I keep on file or via certified mail to my address. Once I have received your written withdrawal of consent, I will remove your review from my website and from any other places where I have posted it. I cannot guarantee that others who may have copied your review from my website or from other locations will also remove the review. This is a risk that I want you to be aware of, should you give me permission to post your review.
3. **Sale of PHI.** I will not sell your PHI.

IV. USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons. I have to meet certain legal conditions before I can share your information for these purposes:

1. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

2. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
3. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
4. For health oversight activities, including audits and investigations.
5. For judicial and administrative proceedings, including responding to a court or administrative order or subpoena, although my preference is to obtain an Authorization from you before doing so if I am so allowed by the court or administrative officials.
6. For law enforcement purposes, including reporting crimes occurring on my premises.
7. To coroners or medical examiners, when such individuals are performing duties authorized by law.
8. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
9. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
10. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
11. For organ and tissue donation requests.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

Disclosures to family, friends, or others: You have the right and choice to tell me that I may provide your PHI to a family member, friend, or other person whom you indicate is involved in your care or the payment for your health care, or to share you information in a disaster relief situation. The opportunity to consent may be obtained retroactively in emergency situations to mitigate a serious and immediate threat to health or safety or if you are unconscious.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on the disclosure of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than in limited circumstances, you have the right to get an electronic or paper copy of your medical record and other information that I have about you. Ask us how to do this. I will provide you with a copy of your record, or if you agree, a summary of it, within 30 days of receiving your written request. I may charge a reasonable cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made.You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, ans other disclosures (such as any you ask me to make). Ask me how to do this. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing

information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by email. And, even if you have agreed to receive this Notice via email, you also have the right to request a paper copy of it.
8. The Right to Choose Someone to Act For You. If you have given someone medical power of attorney or if someone is your legal guardian, that person can make choices about your health information.
9. The Right to Revoke an Authorization.
10. The Right to Opt out of Communications and Fundraising from our Organization.
11. The Right to File a Complaint. You can file a complaint if you feel I have violated your rights by contacting me using the information on page one or by filing a complaint with the HHS Office for Civil Rights located at 200 Independence Avenue, S.W., Washington D.C. 20201, calling HHS at (877) 696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints. I will not retaliate against you for filing a complaint.

VII. CHANGES TO THIS NOTICE

I can change the terms of this Notice, and such changes will apply to all the information I have about you. The new Notice will be available upon request, in my office and on my website.