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**ADULT INFORMATION FORM**

**Email to** [**rchesson@chessoncounseling.com**](mailto:rchesson@chessoncounseling.com) **or Fax to 919-238-3968**

Your Name: Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: City: State: Zip: \_

 ***Check here if okay for billing to be sent to this address.***

**Contact Information** (***Check which numbers are okay to call/leave confidential message***):

 Home Phone:

 Work Phone:

 Cell Phone:

 email:

**Employment Information:**

Employer Name:

Employer Phone:

Employer Address:

**Treatment Information:**

Primary Care Doctor Name:

Phone:

Psychiatrist Name: Phone:

Current Medications: (include dosages)

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

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

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

**In Case of Emergency**: I agree that above information is true and that a Chesson Counseling Services PLLC provider can contact emergency contact if medical or mental health emergency should arise.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: Phone:

Relationship to you: \_\_

Referral Source:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FINANCIAL AGREEMENT**

**You are expected to pay all copays, deductibles, co-insurance, and any past-due balance on your account at the time of service.**

I , agree to pay my co-pay, deductibles, co-insurance, and any past-due balance that may occur on my account that fall inside or outside my insurance benefits. I will be expected to pay by check, cash or credit card. Cash or Check is appreciated.

Please be aware that I do not participate in all insurances. Let me know if you have any questions about that.

I further understand that if I want the therapist’s billing service to file claims with my insurance company, that I am responsible for providing accurate insurance information, verifying my benefits with my insurance company, and understanding my coverage. I also agree to get preauthorization if this is required by my insurance company. I am also expected to notify the therapist of any changes in insurance coverage and that I will be responsible for any services and charges, such as extended sessions, that are not covered by my insurance plan.

**\*If checks are returned an additional $25 fee will be charged and all need to be paid with previous balance at next session. All further payments will need to be made by cash or money order.**

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **MISSED OR CANCELLED APPOINTMENTS**

# ***You will be billed for the cost of your visit for any missed appointment without giving at least 24 hour notice. I cannot bill your insurance for missed appointments. If you reschedule within the week or I am able to schedule another client in your place, I will not charge you.***

# I agree that my credit card or debit card will be charged the full price for a missed or cancelled appointment within the 24 hour period.

# Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Card #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Exp. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# CCV #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Billing Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_

# Signature Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**HIPAA Notice Form**

I am required to provide you with the attached Notice of Policies & Practices to protect the privacy of your health information. Please keep this for your records. As required by Federal Law (HIPAA), please sign to indicate that you’ve received the HIPAA Privacy Practices Form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature Date

**Outpatient Services Agreement**

I have read and understand the Outpatient Services Agreement. My signature indicates that I agree to abide by the terms of this Agreement during our professional relationship.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature Date

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**INSURANCE/PAYMENT AUTHORIZATION**

Insurance

ID# Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to you: \_\_\_\_\_\_\_

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In order to file your insurance for you, please check each box below and sign the following signature- on-file form.**

 I authorize use of this form on all my insurance submissions.

 I authorize my counselor, Rhonda Chesson, to release information needed to obtain mental health insurance benefits

 I understand I am responsible for my bill.

 I understand that my outstanding bills will be sent to the billing address I provided.

 I authorize Chesson Counseling Services PLLC or the billing service representing her, to act as my agent in helping me obtain payment from my insurance carriers.

 I authorize payment directly to Chesson Counseling Services PLLC and hereby assign my right to reimbursement for services rendered to her.

 I permit a copy of this authorization to be used in place of the original.

 I understand that I can rescind this authorization at my request, and in writing, should I make other arrangements for payment of services rendered.

Signature Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# **Authorization for Release of Information**

This form, when completed and signed by you, authorizes me to release/receive protected information from your clinical record to/from the person or entity you designate.

I authorize my counselor, Rhonda Chesson, to release/receive the following information pertaining to myself:

Letter stating intake and session dates

Intake Summary and Diagnosis

Any information needed to obtain mental health insurance benefits

Other (please be specific)

This information should only be released to/from (name and address of person or entity to which the information is to be released):

Name:

Address:

Phone:

I am requesting my counselor to release/receive this information for the following reasons:

At my request

To obtain mental health insurance benefits

To coordinate treatment efforts

Other (please be specific):

I have the right to revoke this authorization, in writing, at any time by sending such written notification to the above office address. However, such revocation will not be effective to the extent that this office has taken action in reliance on the authorization or if this authorization was obtained as a condition for obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my counselor generally may not condition counseling services upon my signing an authorization unless the counseling services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Practices Rule.

Signature Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Outpatient Services Agreement**

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purposes of treatment, payment, and health care operations. HIPAA requires that I provide you with a HIPAA Privacy Practices Form that explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of our first session. Although these documents are long and complex, it is very important that you read them all before our next session. Please note any questions that you might have so that we can discuss them further. After reading this outpatient services agreement, your signature indicates a binding agreement between us. You may revoke this Agreement in writing at any time.

# ***Counseling Services***

Counseling is not easily described in general statements. It varies depending on the personality of both the therapist and the client and the particular problems that the client brings. There are a number of different approaches that can be utilized to address the problems you hope to address. In order for therapy to be most successful, you will be asked to work on things we talk about both during our sessions and at home.

Therapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, and frustration as well as sometimes discussing unpleasant aspects of your life. Therapy has also been shown to have positive benefits for those undertake it. It often leads to significant reduction of feelings of distress, better relationships, and resolutions of specific problems. There are no guarantees that this will happen but it is the goal of the therapy process.

During our first session, I will be asking you questions about what brings you in, what your goals are, and information about your past & current history. I usually take notes during this initial session (but not in later sessions) so that I can prepare an intake summary and begin working with you on establishing treatment goals. By the end of this initial session, I will be able to offer you some impressions of what our work might include if you decide to continue.

You should evaluate this information along with your own assessment about 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 that you select. If you have questions about my procedures, please ask me whenever they arise. If your doubts persist, I will be happy to help you to secure an appropriate consultation with another mental health professional.

# ***Meetings/Missed Session Fee***

If we do decide to continue to meet for therapy sessions, I will schedule sessions as your needs require. Once each appointment time has been scheduled, you are expected to pay a missed session fee unless you provide 24- hour advance notice of cancellation. Missed sessions cannot be billed under insurance.

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# ***Professional Fees***

I accept a varying list of insurances. If I do not take your insurance, I will discuss payment options with you during our initial phone contact. In either case, you will be made aware of approximately what type of fee or insurance co-pay will be charged for each session. Generally, I charge a fee equal to the amount of your session-fee if 24-hour notice of cancellation is not provided. Other professional services such as report writing, SSD reports, attendance at meetings with other professionals (that you have requested & authorized), or preparation of records or treatment summaries may incur a fee for my time.

Occasionally, clients, either during therapy or after, are in legal situations where our work together may be considered relevant. If I am called to court to testify, I will ask that you assume financial responsibility for my preparation time as well as court & legal fees that may be incurred (even if I am compelled to testify by another party).

# ***Billing & Payment***

I will expect you to pay for each session by cash or check at the end of each meeting, unless we have agreed otherwise or unless your insurance coverage pays for the session in full. I do not routinely bill for sessions. Payment schedules for other professional services will be agreed to at the time these services are requested. In circumstances of financial hardship, I may be willing to negotiate a fee adjustment or installment payment plan.

If your account becomes more than 60 days in arrears and suitable arrangements for payment have not been agreed to, I have the options of: 1) adding an additional fee for late payment, 2) using a collection agency, or 3) using legal means to secure payment. If such legal action is necessary, the costs of bringing that proceeding will be included in the claim. I will inform you prior to sending your information (usually name, nature of services provided and amount due) to another source.

# ***Insurance Reimbursement***

If you have a health insurance policy, I will facilitate your receipt of the benefits to which you are entitled including filling out forms and speaking with insurance representatives. You will be held responsible for full payment of our agreed upon fee should your insurance company deny benefits or should your coverage lapse. Therefore, it is very important that you find out exactly what benefits your insurance policy covers. Read your plan carefully and call your provider if you have questions.

Many insurance plans require advance authorization before they will provide reimbursement for my services. These plans often are oriented toward a short-term model and provide only a certain amount of sessions per year. Many insurance companies may only authorize a few sessions at a time and I will need to periodically call them to authorize additional sessions. When I call to authorize treatment or continue our sessions, I will provide them with the minimum amount of information needed, usually including a diagnosis, goals for treatment, and a brief summary of your current functioning. It is possible, but very rare, that they would require a copy of my clinical record. This information will become part of insurance company files and is likely to be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, I have no control over what they do with it. In some cases, they may share the information with a national medical information data bank. By signing this Agreement, you agree that I can provide requested information to your insurance carrier.

If you request it, I will provide you with a copy of any report that I am asked to submit. I make it my policy to inform you along the way of where we stand with your insurance company and what kind of information they have requested. Should your insurance coverage end for some reason, we can discuss an out-of-pocket session fee. You can always choose to select this option and have the right to pay for my services yourself to avoid the complexities of insurance. in

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# ***Contacting Me***

I am only in the office on specific days. Since this is the case, I am often not immediately available by telephone. To reach me, call 919-270-7277 or email rchesson@chessoncounseling.com. Leave a message in my confidential voicemail. Leave your name, phone number, and how I can reach you. Remove any call blocking devices until I return the call. I usually check my voice mail 1-2 times per day during the business week. I will make every effort to return your call the same day or early the following business day. If we have difficulty reaching each other, please leave times when I can reach you and alternative phone numbers.

If you are experiencing a clinical emergency call me directly. If I am available, I will call you back as soon as possible. If you are in crisis and cannot reach me or wait for me to return your call, you should call your family physician, psychiatrist, or Crisis Services (a 24-hour crisis hot-line with counselors that can insure your safety or talk to you about the crisis).

If I know that I will be out of town for an extended period of time, I will have another counselor designated to be on-call for me in crisis situations. If you feel that you might potentially utilize these crises options, please let me know during our session so that we can develop a comprehensive crisis plan.

# ***Professional Records***

Both the legal and professional standards of my job require that I keep Protected Health Information about you in your Clinical Record. Except in situations where you are a danger to yourself (or others) or where others have supplied information to me confidentially, you may examine and/or receive a copy of your Clinical Record. This request must be made in writing. Because they are professional records, they can be misinterpreted or upsetting to lay readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. If you would like me to copy your records for you, I will charge a copying fee of one dollar per page.

# ***Patient Rights***

Please see attached HIPAA Privacy Practices Form for a listing of your rights.

# ***Minors & Parents***

State law gives children of any age the right to independently consent to and receive mental health treatment without parental consent if they request it and if it is determined that such services are necessary and requiring parental consent would have a detrimental effect on the course of the child’s treatment. Even where parental consent is given, children over the age of 12 have a right to control access to their treatment records. If you are age 13 or older, I will request an agreement from your parents that they consent to allow me to maintain your confidentiality. If they agree, I will provide them only with general information about our work together unless I feel that there is a high risk that you will seriously harm yourself, harm another, or are in an abusive situation. In these situations, I will notify them of my concerns about your safety. If they request it, I will provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you (if possible), and will do the best I can to resolve any objections you may have about what I am prepared to discuss with your parents.

# ***Couples***

If you are coming for couple’s therapy, be advised that I do keep your records together. Should any given situation require that I submit records to a third party, both members of the couple will need to give permission for mutual information to be released. I will make every effort to discuss the material to be released with you prior to taking action on any request.

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# ***Confidentiality***

I take the matter of confidentiality quite seriously. The confidentiality of all communications between a client and a counselor is protected by law and I can only release information about our work together with others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are some situations that require only your advance consent. Your signature on this Agreement provides consent for the following activities:

* Occasionally, I may consult with other professionals about strategies or resources that may benefit you. I make every effort to avoid revealing the identity of my clients and often change identifying information in my description. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel it is important to our work together. I will note all consultations in your Clinical Record.
* You should be aware that a secretary at my office might have access to your name or phone number if I need to reach you. All mental health professionals are bound by the same rules of confidentiality. All therapists and staff at this location have agreed not to release any client information unless specifically instructed to by the appropriate mental health professional.

# There are some situations where I am permitted or required to disclose information without either your consent or authorization:

* In most legal situations, you have the right to decline permission for me to release any information about your treatment.
* In some circumstances (like child custody proceedings and situations where your emotional health is relevant), a judge may require my testimony if he/she determines that resolution of the issues demands it. As I am not trained in testifying
* in legal situations, I may not be the right therapist to help you in a court case. Please notify me if you have reason to believe that our work together might be relevant in current or future legal proceedings.
* Legally, I am required to take action to protect others from harm even if it means revealing some information about a client’s treatment. If I believe that a child, elderly person, or disabled person is being abused, I must report this to the appropriate state agency.
* If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions that may include: notifying the potential victim, calling the police, or seeking appropriate hospitalization. If a client threatens to harm him/herself, I am required to seek hospitalization for the client or to contact family members or others who can help provide protection.
* If a government agency is requesting the information for health oversight activities, I may be required to provide the requested information. Examples include: public health authorities, coroner or medical examiner, military/veteran’s affairs agencies, law enforcement, or for national security purposes.
* If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client to defend myself.
* Worker’s compensation cases may require records to be submitted to the Chairman of the Worker’s Compensation Board. These situations are quite rare in my practice. Should such a situation occur, I do make every effort to discuss with you my intended actions prior to making any disclosures.

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**Health Insurance Portability & Accountability Act (HIPAA) Disclosure & Patient Notification of Privacy Rights**

This notice describes how your mental health records may be used and disclosed and how you can get access to this information. Please read it carefully.

1. **Uses and Disclosures for Treatment, Payment, and Health Care Operations.**

We may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

* “*PHI*” refers to information in your health record that could identify you.
* “*Treatment, Payment, and Health Care Operation*”
  + *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychotherapist.
  + *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  + *Health Care Operations* are activities that relate to the performance and operation of our practices.

Examples of health care operations are quality assessment and improvement activities, business-related matters such as licensing or credentialing, accreditation, audits and administrative services, and case management and care coordination.

* “*Use*” applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing examining, and analyzing information that identified you.
* “*Disclosure*” applies to activities outside our [office, clinic, practice group, etc.] such as releasing, transferring, or providing access to information about you to other parties.

**II. Uses and Disclosures Requiring Authorization.**

We may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing us to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you).

Additionally, if you ever want us to send any of your protected health information of any sort to anyone outside our offices, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon request. The requirement that you sign an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that we speak with your physician about your treatment and/or medications. Before we talk to that physician, you will first have signed the proper authorization for us to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: our psychotherapy notes. In recognition of the importance of the confidentiality of conversations between therapist-patient in treatment settings, HIPAA permits keeping ‘psychotherapy notes’ separate from the overall ‘designated medical record.” ‘Psychotherapy notes’ cannot be secured by insurance companies, nor can they insist upon their release for payment of services. “Psychotherapy notes’ are our notes and are defined as follows: “notes recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family

counseling session and that are separated from the rest of the individual’s medical record.” “Psychotherapy notes” are necessarily more private and contain much more personal information about you; hence, the need for increased security of the notes. “Psychotherapy notes’ are not the same as your “progress notes’ which provide the following information about your care each time you have an appointment at our office: assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

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**Health Insurance Portability & Accountability Act (HIPAA) Disclosure & Patient Notification of Privacy Rights**

Certain payers of care, such as Medicare and Workers Compensation, require the release of both your progress notes and psychotherapy notes in order to pay for your care. If we are forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing us to release our psychotherapy notes. Most of the time we will be able to limit reviews of your PHI to only your “designated record set” which includes the following: all identifying paperwork you completed at your initial visit, all billing and reimbursement information, a summary of our first appointment, your mental status and progress notes for each session, your treatment plan, discharge summary, reviews by managed care companies, results of psychological testing, and any

authorizations you have signed. Please note that the actual test questions or raw data of psychological tests are not part of your ‘designated mental health record set.

**III. Uses and Disclosures with Neither Consent Nor Authorization.**

We may use or disclose your PHI without your consent or authorization in the following circumstances:

* Child abuse
* Suspected sexual abuse of a child
* Adult and domestic abuse
* Health oversight activities (i.e. licensing board’s investigations)
* Judicial or administrative proceedings (i.e., court ordered treatment and/or evaluations)
* Serious threat to health or safety (i.e., Duty to Warn law, national security threats)
* Workers Compensation claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

**IV. Patient’s Rights and Our Duties.**

You have a right to the following:

* The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want your bills sent to your home address so we will send them to another location of your choosing.
* The right to inspect and receive a copy of your PHI in the designated mental health record set for as long as PHI is maintained in the record.
* The right to amend material in your PHI, although we may deny an improper request and/or respond to any amendment(s) you make to your record of care.
* The right to an accounting of non-authorized disclosures of your PHI.
* The right to a paper copy of notices/information from me, even if you have previously requested electronic transmission of same.
* The right to revoke any authorization of your PHI except to the extent that action has already been taken.

For more information on how to exercise each of the rights, please do not hesitate to ask us for further assistance. We are required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and our duties regarding your PHI. We reserve the right to change our privacy policies and practices as needed, in accordance with law. Current practices are applicable unless you receive a revision of our policies at a future time.

Our duties as therapists include maintaining the privacy of your PHI, providing you with this notice of your rights and our privacy practices with respect to your PHI, and abiding by the terms of this notice unless it is changed and you are so notified.

**V. Complaints.**

Rhonda Chesson is the appointed “Privacy Officer” for these practices per HIPAA regulations. If you have any concerns that your privacy rights have been compromised, please let her know immediately. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

**No information will ever be released for any sort of marketing purposes.**