Your Inner Pathways Counseling, PLLC.

Sandra Lehmann- MC, LPC, NCC, SEP

North Phoenix Office- 34406 N. 27th Dr. • Bldg. #6 •
Suite #140- Office #112 • Phoenix, AZ 85085

Anthem Office- 4435 West Hower Road • Anthem, AZ 85086

Email: sandi_85044@yahoo.com • Phone: 602-574-3585

Consent for Treatment

Welcome to Your Inner Pathways Counseling, PLLC. In order to assist you in understanding the responsibilities and expectations of counseling, please read and sign the following intake packet. Appointment times range from 50 to 90 minutes depending on your needs. Starting counseling is a major decision and you may have questions. This document is intended to inform you of policies, State and Federal Laws, and your rights. If you have other questions or concerns, please feel free to ask and I will try my best to give you all the information you need.

Psychotherapy Services

Psychotherapy is not easily described in general statements. It will vary depending on the personality of both the client, the therapist and the particular issues brought to session. There are many different methods we may use such as talk therapy, Cognitive Behavioral Therapy, E.M.D.R., Somatic Experiencing and Expressive Arts to address the issues brought to session. Psychotherapy will require a very active effort on both of our parts. You will have to work both during our sessions and at home to achieve the most successful outcome.

Psychotherapy has both benefits and risks. Talking about parts of your history may be painful and risks sometimes include experiencing uncomfortable feelings and sensations associated with memories. We will talk about the benefits and risks of specific therapies in developing a treatment plan. Psychotherapy has also been shown to have benefits for people who undertake it. It often leads to the significant reduction of distress and the increase of satisfaction with yourself, your relationships and the resolution of specific problems. But there are no guarantees about what you will experience.

Our first few sessions will be a time for assessment and I will offer some initial impressions of what our work may include and a treatment plan. We will focus on some specific goals you wish to accomplish and map out a plan. You too will be doing an assessment and determining if the services I propose will fit your needs. As therapy involves a commitment of time, money, and energy it is important that you feel comfortable in the work we are doing together. If you feel uncomfortable with pursuing our work together, I will be happy to assist you in finding another counselor. I welcome and encourage any questions or concerns related to how we are proceeding at any time during treatment.

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Contacting Me

My office phone is my cell phone and it is turned off while I am at the university, in session or otherwise unavailable. My phone is forwarded to a confidential voice mailbox and I will make every effort to return calls as soon as possible. Please leave your phone number each time you call and be aware of the time and the day you call as this is a personal phone as well.

Emergencies

If an urgent emergency situation arises for which the client, parent, guardian, spouse, or partner feels immediate attention is necessary, the person(s) understands that they are to contact the emergency services in the community, **602-222-9444** or **911,** for those services. I will follow those emergency services with standard counseling and support for the client. For any non-life-threatening emergency, please contact Maricopa County Crisis Line at 602-222-9444 and they will direct you to community support available. Please follow up with me so we can set up counseling appointment.

When I will be away from the office, I will provide you with the name of a trusted colleague whom you can contact in an emergency situation.

Email, Text Messaging & Social Media

While email and text messaging have become primary modes of communication it is important to identify that they are neither secure nor confidential means of communication. Communicating organizational needs such as, scheduling, rescheduling or canceling an appointment can be made via email, text message or phone however, please do not send me content related to your therapy session via email or text as it is not a confidential. So much of our work depends on clear, connected communication and I have found that in-person communication works best for therapy related material. Please talk with me about this if you have questions or concerns.

I do not accept friend or contact request from current or former clients on any social networking site (Facebook, Linkedin, etc.). I believe that adding clients as friends or contact on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this please bring them up when we meet and we can talk more about it.

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Professional Records and Confidentiality

Both Arizona law and the standards of my profession require that I keep appropriate treatment records. You are entitled to receive a copy of your records or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and /or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. You will be charged my hourly rate for any professional time spent in responding to information requests.

All information disclosed with in sessions and the written records are confidential and may not be revealed to anyone without your written permission, except where law requires disclosure. There are some limitations to strict confidentiality that protect your welfare and that of the public. These limitations provide for a partial breach of confidentiality only under the MOST SERIOUS CIRCUMSTANCES. I am legally required to take action if:

Professional Records and Confidentiality cont.

- I receive a report of active abuse or neglect of a child or vulnerable adult. I may be required to advise the appropriate authorities. If, in my opinion, you present a danger to yourself or others, I may also be required to make report to the appropriate authorities.

- You threaten serious bodily harm to another person or yourself, I am required to notify the intended victim and appropriate law enforcement agency. Under some circumstances, I may be required to seek hospitalization for you or contact family members or others who can help provide protection.

- A court of law required me to release your records I must do so. Other exceptions exist if you make your mental status a court issue. These will be disclosed on a case-by-case basis.

Records and Your Right to Review Them

Both the law and the standards of my profession require I keep clinical records for seven years. You have the right to review your records at any time except in limited legal or emergency circumstances or when I assess that releasing such information will be harmful to you. In the case of couple's therapy, I will release records only with the signed authorizations from BOTH people involved in treatment.

Litigation Limitation

The nature of our work together involves confidential and sensitive matters. You agree that should there be legal proceedings such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc. neither you nor your attorneys nor anyone else acting on your behalf will contact me to testify in court or at any other proceedings and/or request your records.

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Fee, Payments & Insurance Reimbursement

My individual, couple & family hourly fees are listed on the fee agreement in the intake paperwork. You agree to pay for your session at each meeting unless we have made other arrangements. If I take your insurance you will pay owed amount at the time of your appointment. I charge this amount for other professional services and will breakdown the hourly cost into 15-minute segments if I work for periods less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, preparation of records or treatment summaries and time spent performing any other service requested. If you are experiencing financial difficulties, please discuss this with me. I will provide you with a statement of all charges and payments per your request.

Cancellations

Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of **24-hour notice** is required for re-scheduling or cancelling an appointment. You agree to pay the full fee for sessions missed without such notification and your credit card will be charged for missed session.

I am always happy to discuss any questions or concerns you have about any clinical issue or business policy. Please feel free to talk with me about these matters. I truly appreciate the opportunity to be of professional service to you and I look forward to our work together.

Signatures

Your signature and initials below indicate that you have read and understand the information in this document and agree to abide by its terms.

- I /we agree to receive counseling services with Your Inner Pathways Counseling, PLLC. Sandra Lehmann, MC, LPC, NCC, SEP _____.

- I /we (name/names)_____ give Sandra Lehmann, MC, LPC, NCC, SEP, permission to contact the referral source (name) _____to acknowledge and express appreciation for this referral.

- I /we have read & received a copy of the Fee Agreement, Practice Policies and the HIPPA Notice of Privacy Policies and agree to the terms. _____

Client Name/Names Signature Date

Spouse/ Partner/ Parent/ Guardian Relationship Date

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Date: _____

Name: _____ Birthday: _____ Age: _____

Address: _____

City: _____State: _____ Zip: _____

Cell Phone: _____Work Phone: _____

Home Phone: _____ Email:_____

May I mail to this address? Yes___ No___. May I e-mail to this address? Yes___No___
How would you like to be reminded of appointments? Home phone___ Cell Phone ___Text___ E-mail___
How would you like to receive messages and correspondences? Home___ Cell Phone___ Text___ Email___.

In case of emergency whom should I notify? _____

Relationship to you: _____ Contact number: _____

Current Concerns
Briefly describe your reason for seeking help: _____

When did these problems begin? _____

On a scale of 1-10, rate you current level of distress: (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe) ☐

Education
Level of education: HS☐ College☐ Graduate Degree☐ Other☐

Occupation:_____Employer:_____

How long have you worked there?_____How long in this occupation?_____

If not employed, how long has it been since you worked?_____

What kind of job did you have? _____

What caused you to stop working? _____

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Marriages/ Significant Relationships:

To Whom *Length of Relationship* *Termination of Relationship (if applicable)*

1. _____
2. _____
3. _____

Current Relationship Status:
Single☐ Married☐ Divorced ☐ Separated☐ Widowed☐ Living Together☐

If married, separated, or living together, briefly describe you relationship:

_____

Has your spouse/ partner been previously married? Yes☐ No ☐ Number of times? _____
Number of children from pervious marriages: _____

Children(s) Names *Age* *Sex*

Age of spouse/ partner: _____ Date of Birth: _____ Religion: _____

Level of education: HS ☐ College☐ Graduate Degree☐ Other_____

Occupation: _____ Employer: _____

How long has he/she worked there?_____How long in this occupation?_____

Referral

If you found us on the Internet, please tell us how? (Check if applicable) Google ☐Psychology Today ☐

BCBS Website ☐ UHC Website ☐ Somatic Experiencing Website ☐ Other_____

Who referred you to Your Inner Pathways Counseling _____
May we thank them? Yes☐ No☐

If referred by a doctor, may we have permission to contact that doctor? Yes☐ No☐

Name: _____ Practice Name: _____

Address: _____ Phone: _____

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Extended Family: Parents, Siblings, and Others Close To You

Name	Relationship	Age	Occupation	Problems Alcohol/Mental/Emotional

How was it to grow up in your family?

-
-
-
-
-

With whom are you currently living?

Name	Relationship	Age	Use of Alcohol/Drugs	How do you get along?

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Medical History

Primary Care Physician: _____ Phone: _____

Date of last physical examination: ___ ___ ___

If you are taking any medications, please list:

Medication(s)-Prescription and Over the Counter	*Dosage*	*Prescribed For*

How would you describe your overall health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

List any health problems for which you are currently receive treatment: _____

_____

List any past health problems including accidents: _____

_____

Do you exercise regularly? Yes ☐ No ☐ If yes, describe exercise and frequency _____

_

_____

Briefly describe your eating habits: .

Have you ever had concerns about your eating habits? .

Are you relatively satisfied with your appearance? _____

How much sleep do you get each day? _____ Describe your sleep habits: _____

_____

Psychological/ Emotional Information

Have you ever sought help or been treated for psychological or emotional reasons? Yes ☐ No ☐
If yes, give a brief description of treatment & when it occurred? _____

_____

Have you ever thought about suicide? Yes ☐ No ☐ If so, did you have a plan? Yes ☐ No ☐
Have you ever attempted suicide? Yes ☐ No ☐ If so, how many times? _____
Have you ever felt homicidal? Yes ☐ No ☐ If so, did you have a plan? Yes ☐ No ☐

Have you ever been inpatient for mental health reasons? Yes ☐ No ☐

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Intake Date: ___ ___ ___ Discharge Date_ _Reason: _____
Intake Date: _ _ Discharge Date_ _Reason: _____

Substances Used and/or Abused

Current	Past		Current	Past		Current	Past		Current	Past	
☐	☐	Alcohol	☐	☐	Prescription (RX)	☐	☐	Ecstasy	☐	☐	Barbiturates
☐	☐	Cocaine	☐	☐	OTC Medication	☐	☐	Opiates	☐	☐	Hallucinogens
☐	☐	Marijuana	☐	☐	Narcotics	☐	☐	Amphetamine	☐	☐	Other_____

Do you smoke Yes☐ No☐ If yes, how much/day? _____ Is this a concern? Yes ☐ No ☐
Do you feel you have a problem with drugs or alcohol? Yes☐ No ☐
Have you ever received treatment for drug or alcohol abuse/addiction? Yes ☐ No ☐
If yes, when and where? _____

Legal

Please list and describe any arrests or legal problems (including driving violations): _____

Please check all that apply:

Current	Past		Current	Past	
☐	☐	Depressed Mood	☐	☐	Recurrent and Persistent thoughts/behaviors
☐	☐	Daily Irritability	☐	☐	Difficulty controlling anger/bad temper
☐	☐	Physical abuse	☐	☐	No interest/pleasure in activities
☐	☐	Sexual abuse	☐	☐	Difficulty sleeping/ poor sleep
☐	☐	Increase/decrease need for sleep	☐	☐	Distressing memories that reoccur
☐	☐	Difficulty concentrating	☐	☐	Recurrent distressing dreams
☐	☐	Difficulty making decisions	☐	☐	Delusions (unreasonable thoughts/beliefs)
☐	☐	Fatigue or loss of energy	☐	☐	Do you hear or see things others do not?
☐	☐	Feelings of worthlessness	☐	☐	Not able to control the impulse to steal
☐	☐	Feelings of hopelessness	☐	☐	Preoccupation with or frequent gambling
☐	☐	Recurrent thoughts of death	☐	☐	Sense of reliving traumatic events
☐	☐	Racing thoughts or ideas	☐	☐	Periods of time you can't remember
☐	☐	Rapid mood swings	☐	☐	Intense reactions to certain events/anniversaries
☐	☐	Shortness of breath/dizziness	☐	☐	Avoidance of thoughts or feelings of trauma
☐	☐	Sweating/feeling flushed	☐	☐	Avoidance of activities or situation of trauma
☐	☐	Choking	☐	☐	Detachment from feelings, people, places
☐	☐	Nausea or abdominal distress	☐	☐	Binging/ compulsive overeating
☐	☐	Feeling unreal	☐	☐	Intentional vomiting
☐	☐	Numbness or tingling sensations	☐	☐	Laxative or diuretic use
☐	☐	Fear of dying	☐	☐	Excessive dieting
☐	☐	Sexual orientation issues	☐	☐	Compulsive sexual behaviors
☐	☐	Fear of going crazy	☐	☐	Accelerated heart rate/chest pains

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Check any problem that pertains to you at the present:

☐ Nervousness	☐ Relaxation	☐ Making Decisions	☐ Stress
☐ Shyness	☐ Legal Matters	☐ Self Control	☐ Memory
☐ Separation	☐ Energy	☐ Inferiority	☐ Appetite
☐ Drug Use	☐ Loneliness	☐ Bowel Troubles	☐ Marriage
☐ Anger	☐ Education	☐ Sexual Problems	☐ Work
☐ Sleep	☐ Undereating	☐ Alcohol Use	☐ Overeating
☐ Friends	☐ Concentration	☐ Nightmares	☐ Temper
☐ Fatigue	☐ Ambition	☐ Stomach Problems	☐ Divorce
☐ My thoughts	☐ Parenthood	☐ Health Problems	☐ Age
☐ Finances	☐ My Appearance	☐ Suicidal Thoughts	☐ Future
☐ Sexual Abuse	☐ Children	☐ Career Choices	☐ Weight
☐ Unhappiness	☐ Depression	☐ Headaches	☐ Fears
☐ Self-esteem	☐ Sexual Orientation	☐ Physical Abuse	

Circle everything that has happened to you in the past three years:

☐ Death of a spouse/partner	☐ Marriage Problems	☐ Changes in marital status
☐ Death of another family member	☐ Family Problems (Children, in-laws)	☐ Loss of Job
☐ Major illness or injury–yourself	☐ Financial Problems	☐ Move to another city or state
☐ Major illness or injury–family member	☐ Legal Problems	☐ Other: _____

Please list any additional information that you feel may be helpful _____

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Initial _____
Update _____

Counseling Treatment Plan

Therapy is a collaborative process with goals to be mutually determined by you and your therapist. To make effective progress, we need specific, concrete goals. Please think about your goals for our work together.

1.What would you like to change/ improve? _____

_____

2. What is your goal, as it relates to question #1? _____

_____

To achieve these goals, what are you willing to do? Check all that apply:

- ◯ Attend counseling regularly (how often?) _____
- ◯ Do homework between sessions
- ◯ Collaborate with my counselor in designing my treatment
- ◯ Try out some new behaviors my counselor might suggest

---------- **(To be completed by therapist)**----------

Problem: _____

Goal: _____

Format:

Individual Counseling ☐ Couples Counseling ☐ Family Counseling ☐

Methods:

☐ Cognitive Behavioral Therapy (identify cognitive distortions/ irrational beliefs and develop skills for corrective thought process)

☐ Evaluate Role of Childhood Trauma via autobiographical timeline

☐ (E.M.D.R.) Eye Movement Desensitization and Reprocessing

☐ (S.E.) Somatic Experiencing ☐ Expressive Arts Therapy

☐ Psychoeducation- Identifying and coping with triggers (scaling, identifying irrational beliefs, flexible thinking, mindfulness techniques, etc.)

☐ Other_____

_____ Client Signature _____Date

_____ Spouse/ Partner/ Parent/ Guardian _____ Date

_____ Sandra Lehmann MC, LPC _____Date

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Fee Agreement

Payment is due at the time of service. The fee for services is as follows:

Individual, Couple, and Family sessions:
75- minute session-(Sliding Scale) $150.00-$ 200.00
50- minute session- (Sliding Scale) $75.00-$165.00

Group sessions:
75 – minute group session- $ 50.00 per session *

*Group admission requires an initial intake a 50-minute session, at the rate of $100.00. Pending the amount of group sessions, the full amount of the group must be paid in full or can be split in two payments. Example, if there are 8 group sessions, the total required is $100.00 + $400.00.

Payment can be made via for following:
Cash, Check, Debit Card, Credit Card, Health Savings Account (HSA), or Flex Spending Account.

If you have Out of Network benefits, your insurance may reimburse you for a portion of this fee. It is your responsibility to contact your insurance company and inquire what your out of network coverage entails**.** If you do have this type of coverage, you must still pay at the time of service and you will be responsible for pursuing any reimbursement from your insurance company. Upon request, I can provide you with a "Superbill" for services to submit to your insurance.

At your first appointment, you will be asked to give your credit card information and agree to authorize Your Inner Pathways Counseling, PLLC to charge that card for your initial session in the event that other payment(s) have not been made at the time of service, or in the event of a late cancellation or a missed session that was not cancelled prior to 24 hour notice.

Initial _____

Phone Contact is billed at the same rate as face-to-face session. There is no charge for phone calls lasting 15 minutes or less.
Other Professional Services: I will prorate my hourly cost into 15minute segments if I work for periods less than one hour. Other professional services include report writing, telephone conversations lasting longer than 15 minutes, preparation of records or treatment summaries and time spent performing any other service you may request of me within my scope of practice.
Cancelations and Missed Appointments:
Please be aware that you may leave a voice mail, text or e-mail to cancel our appointment 24 hours a day as long as you cancel your appointment at least 24 hours in advance from the time of your scheduled appointment, you will not be charged. However, you will be billed the full session rate

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(whatever your session length was) for any cancellations made less than 24 hours prior to your scheduled appointment**.** Please be aware that insurance generally does not reimburse clients for missed or late cancelled appointments.

Unpaid Balances

Please be aware that Your Inner Pathways Counseling, PLLC **will be unable to continue services once you accrue an overdue balance of $260.00 or more or if you no-show three consecutive sessions.** Your file will be closed and a letter notifying you of this will be sent to the address listed on your intake paperwork.

Initial: _____

I authorize the following credit card to be on file and for Your Inner Pathways Counseling, PLLC to charge this credit card under the following circumstances: **1) services received for which other payment has not already been made, 2) appointment that I miss or canceled within less than 24 hours of my scheduled appointment time and 3) phone consultations lasting longer than 15 minutes & any other professional service requested of me.** Once card information is entered into the billing program card numbers are destroyed for your protection.

Credit Card Type:

Visa ☐ Master Card ☐ Discover ☐ American Express ☐

Health Savings Acct. ☐ Flex Spending Acct. ☐

Name as it appears on the Card: _____

Credit Card Number: _____ _____ _____ _____

Expiration Date: _____ CVC Code: _____

Client's printed name: _____

Signature: _____ Date: _____

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CLIENT NOTIFICATION OF PRIVACY RIGHTS- (HIPAA)
FEDERAL MEDICAL PRIVACY RULE: 45 CFR 164

This document describes how your mental health records may be used and disclosed and how to get access to this information.

Uses and Disclosure for Treatment Payment and Health Care Operations

I may use or disclose your Protected Health Information **(PHI)** for treatment, payment, and health care operational purposes with your consent.

To help clarify these terms, here are some definitions:

- **PHI-** refers to information in your health record that could identify you.

Treatment, Payment, and Health Care Operations:

- **Treatment**– is providing, coordinating or managing your health care and other services related to health care. An example of treatment would be consulting with another healthcare provider, such as a family physician or another counselor/ psychotherapist/ psychologist/ psychiatrist.
- **Payment-** is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for health care or to determine eligibility or coverage.
- **Health Care Operations-** activities that relate to the performance and operation of counseling practice. Examples of health care operations are business related matters such as; bookkeeping, administrative services, case management and coordination of care.
- **Use-** applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and/or analyzing information that identifies you.
- **Disclosure-**applies to activities outside my office such as releasing, transferring or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained. An authorization is written permission above and beyond the general consent that permits only specific disclosures. In cases when I am asked for information for purposes outside of treatment, payment or health care operations. I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes made about our conversation during a private, group, joint or family counseling session, which are held separate from the rest of your medical record. These notes are given greater degree of protection than PHI.

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You may revoke all authorization (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization, or (2) if the authorization was obtained as a condition of obtaining insurance coverage; law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent or Authorization

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

- **Child abuse-** I am required to report PHI to the appropriate authorities when there are reasonable grounds to believe that a minor is or has been the victim of neglect, physical and /or sexual abuse.

- **Adult and Domestic Abuse-** I am required to disclose PHI when there are reasonable grounds to believe that abuse or neglect of an adult is or has occurred or that exploitation of the adult's property has occurred.

- **Health Oversight Activities-** If the Arizona Board of Behavioral Health Examiners (AZBBHE) is conducting an investigation, then I am required to disclose PHI upon receipt of a subpoena from the AZBBHE.

- **Judicial and Administrative Proceedings-** If you are involved in a court proceeding and a request is made about professional services I provided to you and /or the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety-** If you communicate to me an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and I believe you have the intent and ability to carry out such a threat, I have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police and to order and initiate a hospitalization procedure. If I believe there is an imminent risk that you will reflect serious harm on yourself, I may disclose information in order to protect you.

- **Worker's compensation-** I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Your Inner Pathways Counseling, PLLC.

Sandra Lehmann- MC, LPC, NCC, SEP

North Phoenix Office- 34406 N. 27th Dr. • Bldg. #6 •
Ste #140- Office #112 • Phoenix, AZ 85085
Anthem Office- 4435 West Hower Road • Anthem, AZ 85086
Email: sandi_85044@yahoo.com • Phone: 602-574-3585

Patient's Rights and Counselor Duties

- **Right to Request Restrictions-** You have the right to request restrictions on certain uses and disclosures of PHI. However, I am not required to agree to a restriction you request.

- **Right to Receive Confidential Communication by Alternative Means and at Alternative locations-** You have the right to request and receive confidential communication of PHI by alternative means at alternative locations. For example, you may not want a family member to know that you are seeing me. On your request, I will send your statement/bills to another address.

- **Right to Inspect and Copy-**You have the right to inspect or obtain a copy of PHI regarding mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- **Right to Amend-** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- **Right to an Accounting-** You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- **Right to a Paper Copy-** You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Counselor's Duties

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices in the notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you written notice.

Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on October 01, 2017. I reserve the right to change the terms of this notice and make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in writing.

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CLIENT NOTIFICATION OF PRIVACY RIGHTS- ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.
I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand the *Client Notification of Privacy Rights* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the *Client Notification of Privacy Rights* from time to time and that I may contact this organization at any time to obtain a current or a more detailed copy of the *Client Notification of Privacy Rights.*

I understand that I may request in writing to restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that the treating therapist is not required to agree to my requested restrictions and if they do agree then they are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

OFFICE USE ONLY: I attempted to obtain patient's **signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:**

Date:	**Initials:**	**Reason:**