Robin Goldstein, MS LPC

1490 S Price Rd, Suite 316
Chandler, AZ 85286

New Client Information

Today's Date: _____

I. Client Information

Name: _____ Social Security #: _____ - ___ - _____

Birth Date: ___ / ___ / _____ Age: _____ ❑ Male ❑ Female ❑ Transgender

Address:_____ City:_____ State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ @ _____

In case of emergency, please notify:

Name:_____ Phone:_____ Relationship: _____

Please complete this section for others residing in the client's home.

NAME	BIRTH DATE	AGE	RELATIONSHIP TO CLIENT	GENDER

II. Client Occupational/Educational Status

Are you currently employed? ❑ Yes ❑ No ❑ Full-Time ❑ Part-Time Job Title:

_____

Employer:_____

If you are not employed, please check any of the following: ❑ Retired ❑ Unemployed ❑ Disability ❑ Student

II. Referred By: If you were referred to me by someone, what is the person's name?

_____

IV. Client's Health Status

Current or chronic medical issues: _____

Primary Care Doctor: _____ Phone: _____

V. Client's Medication History

Please list any previous medications taken for emotional or substance abuse problems.

Name:	Name:	Name:
Dose (mg):	Dose (mg):	Dose (mg):
Frequency:	Frequency:	Frequency:

Please list any current medications taken for emotional or substance abuse problems.

Name:	Name:	Name:
Dose (mg):	Dose (mg):	Dose (mg):
Frequency:	Frequency:	Frequency:

Other medications: _____

Prescribing Physician For Current Medications: _____ Phone: _____

VI. Client's Mental Health History

Have you had prior mental health related services? ❑ YES ❑ NO

	Therapist/Facility	Dates	Duration	Outcome
Prior Therapy	1) 2) 3)	1) 2) 3)	1) 2) 3)	1) 2) 3)
Prior Hospitalization(s)	1) 2) 3)	1) 2) 3)	1) 2) 3)	1) 2) 3)

VII. Reasons for Seeking Help (please check all that apply):

- ❑ Emotional health
- ❑ Substance use/abuse
- ❑ Suicide risk
- ❑ Marital/relationship
- ❑ Family issues
- ❑ Eating disorder
- ❑ Abuse/violence
- ❑ Identity Concern
- ❑ Work-related
- ❑ Children
- ❑ Health-related
- ❑ Spiritual/Religious
- ❑ Financial
- ❑ Legal
- ❑ Other:_____

_____

Please briefly describe why you are choosing to enter treatment at this time:

_____

_____

_____

_____

VIII. Client Background Information: The following information is optional but will help me to better serve you.

Your Ethnicity/Race

- ❑ American Indian /Alaskan Native
- ❑ Asian or Pacific Islander
- ❑ African-American/Black
- ❑ Hispanic/Latino/a
- ❑ Caucasian/White
- ❑ Bi-Racial
- ❑ Multi-Racial
- ❑ Other:_____

Your Highest Level of Education

- ❑ No High School
- ❑ Some High School
- ❑ High School Diploma
- ❑ Some College/Technical School
- ❑ Associate's Degree
- ❑ Professional Degree
- ❑ Bachelor's Degree
- ❑ Master's Degree
- ❑ Doctoral Degree

Your Relationship Status

- ❑ Single & Not Partnered
- ❑ Living Together/Not Married
- ❑ Widowed
- ❑ Partnered But Not Married
- ❑ Married/Partnered
- ❑ Separated
- ❑ Divorced

Your Sexual Orientation

- ❑ Heterosexual
- ❑ Gay/Lesbian
- ❑ Bisexual
- ❑ Not sure/questioning

Your Family Background

	Names	**Ages**	**Highest Level of Education**	**Occupation**
Parents				
Were you adopted? ❑ YES ❑ NO				
Have your parents ever been divorced? ❑ YES ❑ NO If Yes, when? _____				
Are both parents still alive? ❑ YES ❑ NO If Yes, please list the age of the parent(s) at time of passing above.				
Siblings				
Children				
Any history of mental illness such as depression or anxiety in your family? ❑ YES ❑ NO				
Any history of suicide in your family? ❑ YES ❑ NO				
Any history of drug and/or excessive alcohol use in your family? ❑ YES ❑ NO				
Any history of abuse in your family? ❑ YES ❑ NO				
Have you or any members of your family had legal problems? ❑ YES ❑ NO				
Have you ever served in the military? ❑ YES ❑ NO If Yes, which branch? _____				

Current Concerns

Below is a list of commonly experienced concerns. To facilitate the best assessment of your current situation, please circle the number indicating the degree to which each item is presently a concern for you using the following scale:

Not at all	A little bit	Moderately	Quite a bit	Very much
0	1	2	3	4

1.	Dealing with stress or pressure	0	1	2	3	4
2.	Adjusting to a new work or living environment	0	1	2	3	4
3.	Feeling depressed, sad, or down	0	1	2	3	4
4.	Establishing a career direction	0	1	2	3	4
5.	Death or illness of a significant person	0	1	2	3	4
6.	Performance anxiety, work or academic progress	0	1	2	3	4
7.	Time management	0	1	2	3	4
8.	Difficulties related to sexual identity or sexual orientation	0	1	2	3	4
9.	Feeling anxious, fearful, worried, or panicky	0	1	2	3	4
10.	Feeling unmotivated, procrastination, or difficulty concentrating	0	1	2	3	4
11.	Feeling irritable, tense, angry, or hostile	0	1	2	3	4
12.	Relationships with family members (parents, siblings, children, relatives)	0	1	2	3	4
13.	Money, finances	0	1	2	3	4
14.	Feeling lonely, isolated, or uncomfortable with others	0	1	2	3	4
15.	Values, beliefs, religion, or spirituality	0	1	2	3	4
16.	Past sexual experiences (sexual abuse, incest, unwanted sexual behavior)	0	1	2	3	4
17.	Low self-esteem or self-confidence	0	1	2	3	4
18.	Legal matters	0	1	2	3	4
19.	Someone else's habits or behaviors	0	1	2	3	4
20.	Unwanted/out-of-control behaviors or habits	0	1	2	3	4
21.	Problems with assertiveness or shyness	0	1	2	3	4
22.	Sleep problems	0	1	2	3	4
23.	Rape, sexual assault, or sexual harassment	0	1	2	3	4
24.	Eating problems (bingeing, restricting, low appetite, vomiting, laxative use, etc.)	0	1	2	3	4
25.	Relationships with romantic partner/spouse	0	1	2	3	4
26.	Physical health problems (headache, pain, fainting, injury, fatigue, etc.)	0	1	2	3	4
27.	Sexual matters (pregnancy, sexually transmitted disease, sexual functioning, etc.)	0	1	2	3	4
28.	Urge or plan to harm another person	0	1	2	3	4
29.	Relationships with supervisors or instructors	0	1	2	3	4
30.	Suicidal thoughts and feelings	0	1	2	3	4
31.	Racial, sexual or other discrimination	0	1	2	3	4
32.	Feelings of guilt or self-criticism	0	1	2	3	4
33.	Weight or body image problems	0	1	2	3	4
34.	Your use of alcohol, drugs, or other substances	0	1	2	3	4
35.	Unusual perceptual experiences (hearing voices, seeing things, etc.)	0	1	2	3	4
36.	Other_____	0	1	2	3	4

OUTPATIENT SERVICES CONTRACT

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 new federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (Arizona Notice Form) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, 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. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us.

You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, as well as the particular problems you discuss. There are many different methods that I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. **Instead, it requires a very active effort on your part**. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you 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, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you may experience.

The first 2 to 3 sessions will involve an evaluation of your needs and may include some formal psychological testing. 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. By the end of the evaluation, you will be offered some first impressions of what our work will include and a treatment plan will be developed, if you decide to continue with therapy. You are strongly encouraged to evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a commitment of time, money, and energy, so it is recommended that you be thoughtful 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 refer you to another mental health professional for a second opinion.

PROFESSIONAL FEES, BILLING, PAYMENTS

I am only and 'out of network' provider, thus I do not participate with any insurance plans. All payments are due at time of service, either in cash or credit card. Checks are not accepted. The initial consultation is $150. Any subsequent appointments are $135. I will usually schedule one appointment hour of 45-50 minutes duration per week, at a time that we agree on, although some sessions may be longer or more or less frequent. In addition to weekly appointments, I charge $135 per hour for other professional services you may need including: report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service that you may request of me. If you become involved in legal proceedings that require my participation (see provisions for serving as a treating clinician), you will be expected to pay for my professional time, including preparation and transportation costs.

Because of the complexity of legal involvement, I charge $295 per hour with a four-hour minimum requirement for preparation, travel time, and attendance at any legal proceeding. In addition this fee will need to be paid in advance.

Client Initial

I require a **24 hour** advanced notice, business days, for any cancellation of a scheduled appointment. It is possible to call and leave a message 24 hrs a day. Your full session fee will be invoiced any cancellation or reschedule made with less than **24-hours notice,** unless we both agree that you were unable to attend due to circumstances beyond your control.

Client Initial _____

CONTACTING ME

I am often not immediately available by telephone. While I am usually in my office between 12 PM and 8 PM, I probably will not answer the phone when I am with a client. I can be reached at any time by email at **Robin@azSchwartzGroup.com**. If you need to reach me after ours by phone for urgent matters, then I can be paged through the answering service at the Arizona Schwartz Group. I will make every effort to return your call on the same day that you place it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times that you will be available. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

I am completely independent in providing you with clinical services and I alone am fully responsible for those services including maintaining clinical records of our interactions. The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee of 25 cents per page. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request. You will be charged an appropriate fee for any professional time spent in responding to information requests, although I am sometimes willing to conduct a review meeting without charge.

CLIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent.

Your signature on this Agreement provides consent for those activities, as follows:

I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are 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. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Policies and Practices to Protect the Privacy of Your Health Information).

You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

As required by HIPAA, I have a formal business associate contract with certain businesses in which it/they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract. Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement. If a 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.

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

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided you, such information is protected by applicable therapist-client privilege law. I cannot provide any information without your or your legal representative's written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

- If a client files a worker's compensation claim, and I am providing services related to that claim, I must, upon appropriate request, provide appropriate reports to the Workers Compensation Commission or the insurer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child under 18 who I have examined is or has been the victim of injury, sexual abuse, neglect or deprivation of necessary medical treatment, the law requires that I file a report with the appropriate government agency, usually the Office of Child Protective Services. Once such a report is filed, I may be required to provide additional information.

- If I have reason to believe that any adult client who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect or financial exploitation, the law requires that I file a report with the appropriate state official, usually a protective services worker. Once such a report is filed, I may be required to provide additional information.

- If a client communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim, and I believe that the client has the intent and ability to carry out such threat, I must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. 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 now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

MINORS & PARENTS

Clients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

With my signature, I acknowledge that I have read the above information, or it has been read to me. I acknowledge that I have received answers to my questions I may have had and that I understand the content of the information above and agree to abide by its terms during our professional relationship. I hereby authorize the release of any medical information necessary to process medical claims on my behalf. I also authorize the payment of any governmental or private insurance benefits directly to Robin Goldstein, LPC. I acknowledge that I am responsible for all services rendered to me and/or members of my family. I also understand that I am obligated to pay for all services should my insurance eligibility be denied.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Your signature also indicates that you consent to treatment for yourself.

Signature of Client _____ Date _____

Printed Name: _____

Therapist's Signature _____ Date _____

Signature of Parent or Guardian _____ Date _____

Printed Name of Parent or Guardian: _____

Therapist's Signature _____ Date _____

Revised: 06/23/2014

Robin Goldstein, LPC
1490 S Price Rd, Suite 316
Chandler, AZ 85286

Collections Policy

It is my policy to obtain and maintain on record a valid Visa or MasterCard and authorizing signature. This will remain in your confidential file as a guarantee of payment and allows us to avoid having to take collections action against any client. **No charge will be billed to this account unless the owner of the card fails to reconcile debts to me**. If you do not wish to complete this form you may seek services elsewhere and I will assist you with a referral.

If you elect to use your insurance/EAP benefits to pay for services then you will need to complete this form in its entirety as having benefits is **not** a guarantee of payment. If I have a contract with your managed care insurance company/EAP the billing procedures of that company will be followed. I will make several attempts to collect from your insurance company /EAP including a telephone call to said company if necessary; however, in the event that any insurance company/EAP obligated by contractual agreement to make payments on your behalf for services provided, refuses to make such payment you will become personally responsible for that amount. I will make three attempts to notify you of the debt in order to provide you the opportunity of calling your insurance company and/or clearing your account. If the account is not cleared within **90** days you hereby authorize me to collect any outstanding amount on the credit card listed below. In the event charges are billed to this account, you will be sent a copy of the credit card charge and reconciled bill in the mail within 7 to 10 business days.

This signed credit card collections policy is for use only for services rendered at my office.

Client's Name: _____

VISA **MasterCard**

Card Member Name: _____

Card Number: _____

CVC Number:_____

Expiration Date: _____

Card Member Signature: _____ **Date:** _____

Therapist Signature: _____

CONFIDENTIAL

ARIZONA NOTICE FORM

(Retain for Your Records)

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I 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 Operations*"
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  – *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 your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [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

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 those instances 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 I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (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.

III. Uses and Disclosures with Neither Consent nor 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 I have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.
- *Adult and Domestic Abuse* – If I have the responsibility for the care of an incapacitated or vulnerable adult, I am required to disclose PHI when I have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred.
- *Health Oversight Activities* – If the Arizona Board of Behavioral Health is conducting an investigation, then I am required to disclose PHI upon receipt of a subpoena from the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about the professional services I provided 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 in order to initiate hospitalization procedures. If I believe there is an imminent risk that you will inflict 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.

IV. Client's Rights and Psychologist's Duties

Client's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and 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 bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my 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.
- Psychologist'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 described in this 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 a copy during one of our sessions or in the mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at (480) 949-2075. If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint me at 1166 E. Warner Rd. Ste. 101-S Gilbert, AZ. 85296. **You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.** You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14th, 2003

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice either in person or by mail.