Insight Counseling Center

INFORMATION SHEET

CLIENT INFORMATION **Date: _____**

Name: _____ Employer: _____

Address: Street_____ Occupation: _____

City _____Zip_____ Work Phone: _____

Home Phone: _____ OK to leave message? ____yes ____no

Cell/Alt. Phone #: _____ OK to leave message? ____yes ____no

Email Address _____ Ok to send message/newsletter? ___yes ___no

Birth Date: _____

IN CASE OF AN EMERGENCY

I authorize _____ to contact the following person(s):

Name_____ Relationship_____ Phone(____)_____

Name_____ Relationship_____ Phone(____)_____

PRIMARY INSURANCE INFORMATION **Circle:** self parent spouse guardian

Name _____ Insured's Employer _____

Last First M.I.

Address _____ Insurance Phone (____) _____ _____

(if different)

_____ Insurance Co _____

Home Phone _____ Plan Name _____

(if different)

Birth date _____ Insured's ID # _____

Soc. Sec. # _____ Policy Group # _____

Authorization to Release Information: I authorize the Release of any medical or other information necessary to process insurance claims.

_____

Signature Date

Authorization to Pay Benefits to Provider: I authorize payment of benefits directly to the therapist for services provided. Where applicable, I also request payment of government benefits to the party who accepts assignment.

_____

Signature Date

For Office Use Only: Primary Therapist _____**Diagnosis** _____**Date Emailed** _____

930 Logan Street
Denver, CO 80203

720-503-2405

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PERSONAL INFORMATION

Name:_____

Referred by: _____

Previous Counseling/Treatment:

(Who) _____ (Where) _____ (When) _____

(Results)_____

(Who) _____ (Where) _____ (When) _____

(Results)_____

Nature of Current Problems: _____

_____

_____

_____

Others Living in the Home:

Name _____ DOB ___/___/___ School/Employer: _____

Name _____ DOB ___/___/___ School/Employer: _____

Name _____ DOB ___/___/___ School/Employer: _____

Name _____ DOB ___/___/___ School/Employer: _____

MEDICAL INFORMATION

Primary Care Physician: _____ Date of Last Visit: _____

Address: _____ Medical Issues: _____

Physician's Phone: _____ _____

Allergies: _____ Current Medications: *(Inclued dosage and length of usage)*_____

Adverse Reaction to Medications _____

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DISCLOSURE STATEMENT

Welcome to Insight Counseling Center. We want your experience here to be positive and growth promoting. Following is some information about my policies and procedures. Please take your time, read this carefully, and ask us if you have any questions.

1.General Information about Your Therapist

Mallory Crouch, LCSW, LAC
930 Logan Street
Denver, CO 80203

Phone: 720-503-2405
Email: MCrouch@InsightCounselingCenter.com
Website: InsightCounselingCenter.com

Education
Master of Social Work, University of Denver 2010
Bachelor of Social Work, Colorado State University 2006
40 hours of EMDR Therapy Training (trauma training) Maiberger Institute 2016
Behavioral Health/Addictions Counseling Licensure Training Odyssey Training Center 2011-2015

Experience
Insight Counseling Center Therapist, February 2016-Present
Pennock Center for Counseling Staff Therapist/Internship Coordinator, 2013-2016
BI, Inc. High Risk/High Needs Intensive Outpatient Therapist, 2010-2013

Licensure
State of Colorado, Licensed Clinical Social Worker, License number .09923671
State of Colorado, Licensed Addiction Counselor, License number .0000701

2. Mental Health Regulation and Types of Licenses and Registration. The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Colorado Board of Psychologist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303)894-7800. As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a masters degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required. **I am a Licensed Clinical Social Worker and a Licensed Addiction Counselor.**

3. Information about Therapy and Fees. You are entitled, to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy, if known, and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

Insight Counseling Center

My fundamental approach to therapy is trauma informed, cognitive behavioral, solution-focused. I am trained in Eye Movement Desensitization, and Reprocessing Therapy (EMDR) which is a specific method for treating Post-Traumatic-Stress Disorder, phobias, anxiety, depression and compulsive/addictive behaviors. I also have training in family systems therapy, group therapy, motivational interviewing and trauma work. Generally speaking, my therapeutic approach involves looking at underlying issues that cause current-day issues or pain. Length of therapy varies, depending on the nature of the problem and what the client wants from therapy. While some issues may be resolved within a few sessions, deep level change often takes time. No one can guarantee the outcome of therapy. Therapy depends on the fit between client, therapist and therapeutic method and is dependent on the client's motivation and willingness to experience the anxiety of the change process. Please feel free to discuss with me at any time your goals for therapy and any thoughts you have about the work we are doing together. If at any point you would like to try another approach, please feel free to talk with me about this and I will be happy to provide appropriate referrals.

My Availability:
In an emergency you may try to reach me by phone not email, indicating that it is an emergency, and I will try to get back to you as soon as possible. Phones are off while in session, at night, on vacation, etc. However, as a sole practitioner I do not offer 24-hour crisis intervention or after hour availability.
If you are unable to reach me in case of an emergency, and you cannot wait for me to call you back, contact your family physician or the nearest emergency room and ask for the psychiatrist/psychologist/mental health worker on call.
Other alternatives are the Denver Metro Area crisis line: 888-885-1222, simply call 911, or going to the emergency room as needed.
You agree to first contact emergency services and take necessary steps to remain safe in the event of a life threatening emergency including suicidal ideation.

No Show/Late Cancellation Policy
In an effort to accommodate as many clients as possible during the limited time available during a given week, it is necessary to have a cancellation policy that is fair and reasonable for all concerned. It is in the spirit of showing respect for each other that the following policy was created.
The fee for individual psychotherapy is $135 an hour. You will be charged $70 for missed sessions unless you provide 24-hours notice/one business day notice. There are no exceptions to this policy.

4. Prohibited Relationships. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

5. Confidentiality. Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 and the Notice of Privacy Rights you were provided as well as other exceptions in Colorado and Federal law. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The exceptions to confidentiality are as followed:

- I am required by law to report suspected child abuse, without an investigation, to the proper authorities.
- If you are a serious harm to yourself or another, I will take action, such as seek hospitalization without your consent. Any action I take without your consent will be discussed with you.
- I am required to report any suspected threat to national security to federal officials
- I am required to report any threats against locations such as churches, schools, theaters, workplaces etc. to law enforcement.

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- I may be required by Court Order to disclose treatment information
- If I am unable to collect my agreed upon fee, I may send your name and address to a collection agency.
- If you file an official complaint or a lawsuit against me, according to Colorado law, your right to confidentiality will be waived.
- As a standard of practice, I may seek consultation from another mental health professional.
- Clerical persons hired by me may have access to limited confidential information. This information is protected from further disclosure and is used solely for administrative purposes.
- New law additionally clarifies that mandatory reporters (as defined in C.R.S. 19-3-304) must make a report regarding an adult's disclosure of childhood abuse under the following conditions:
  If the mandatory reporter has reasonable cause to know or suspect that the perpetrator of the suspected abuse or neglect has subjected any other child currently under eighteen years of age to abuse or neglect or to circumstances or conditions that would likely result in abuse or neglect; or if the alleged perpetrator is currently in a position of trust, as defined in section 18-3-401 (3.5), C.R.S., with regard to any child currently under eighteen years of age.

I am bound by confidentiality in the client-therapist relationship. That means I may not talk to anyone about our work together, including family members, unless I have your written permission, or you are under the age of 18 years. There are exceptions to this mandated law as noted above. If you have seen another therapist or psychiatrist and that information would be helpful to your work with me, you must first agree to sign a written release before I may speak with this professional.

Email (to email paper work/receipt for sessions):_____
If you choose to correspond with me through email, know the information is not confidential. Please note that if you need to communicate confidential information or need to cancel an appointment, you must do this through voicemail. If you would like to be added to my free e-newsletter, please initial here ____.

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party. I acknowledge receipt of the "Notice of Privacy Practices" describing the use and release of my health information and my health information rights.

_____ _____
Print Client's Name Client's Date of Birth

_____ _____
Client's or Responsible Party's Signature Date

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CURRENT CONCERNS AND RESOURCES

CONCERNS & GOALS: What brings you to counseling / therapy? What do you hope to accomplish? _____

_____

_____

_____

Spiritual/Faith Information: What role does your spirituality or religious faith play in your life?

_____

_____

Strengths/Support System/Community Resources: _____

_____

_____

HEALTH: Check and describe the following, with dates, as they apply to you:

_____ Current / chronic medical conditions / infectious diseases _____

_____ Recent weight changes: Lost / gained _____ lbs. in _____ weeks/months? Intentional? Y N

_____ Serious illnesses / injuries / traumas _____

_____ Surgeries / hospitalizations (medical / psychiatric) _____

Rate your current distress level for each symptom / concern that applies to you**, using the scale below**:

0 1 2 3 4 5 6

None Very little Mild Moderate	Considerable Severe Maximum
_____ Depression	_____ Alcohol / other drug abuse (who?) _____
_____ Hopelessness	_____ Nicotine addiction – amt. _____
_____ Anxiety	_____ Caffeine addiction – amt. _____
_____ Panic attacks	_____ Eating disorders
_____ Withdrawn behavior	_____ Compulsive gambling
_____ Social Anxiety	_____ Pornography
_____ Loss of / increased appetite	_____ Sexual addiction
_____ Mood swings	_____ Computer / internet addiction
_____ Anger / rage	_____ Other addictions (identify) _____
_____ Fearfulness	_____ Communication problems
_____ Guilt	_____ Sexual problems
_____ Suicidal thoughts	_____ Marital / relationship conflicts
_____ Suicidal actions	_____ Domestic violence
_____ Homicidal thoughts / actions	_____ Blended family problems
_____ Obsessive thoughts _____	_____ Conflict with parents
_____ Compulsive behaviors _____	_____ Conflict with siblings
_____ Paranoid thoughts / behaviors	_____ Conflict with children
_____ Hallucinations (audio / visual)	_____ School / work conflicts
_____ Memory problems (short term / long term)	_____ Emotional abuse (past / current)
_____ Concentration / lack of focus	_____ Physical abuse (past / current)
_____ Perfectionism	_____ Sleep problems (describe)
_____ Health concerns	_____
_____ Hormonal / endocrine imbalances	_____ Other (describe)
_____ Self esteem concerns	_____
_____ Grief / losses (identify) _____	_____ Sexual abuse (past / current)
_____ Loss of meaning in life	_____ Legal problems
_____ Alcohol / other drug abuse (self)	_____ Financial problems
	_____ Job / employment problems

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Drug and Alcohol Information

List all of the prescription and over-the-counter drugs you are taking

_____

_____

_____

	FIRST USE	# DAYS PER WEEK	LAST USED
Beer			
Liquor			
Wine			
Marijuana			
Cocaine/crack			
Methamphetamine			
Heroin			
Prescription Pain killers			
PCP, LSD			
Ecstasy			
Other			

	Circle	
Have you ever felt like you should cut down on your drug or alcohol use?	yes	no
Has a friend or relative expressed concerns about your use?	yes	no
Have you ever felt guilty about your drinking or drug use?	yes	no
Have you ever had to take a drink or use a drug the next day to steady your nerves?	yes	no
Are you a recovering alcoholic or a recovering drug addict?	yes	no
Is there a history of problems with drug or alcohol use in your family?	yes	no

To be completed by adolescents (12 yrs to 17 yrs)

Have you ever used alcohol or drugs before or during school?	yes	no
Have you ever missed school (or been truant) because of use or just to use?	yes	no
Have you ever avoided non-users?	yes	no

How often do you get drunk/high? _____

About how often do you use more than one drug when you get high? _____

Is there a history of problems with drug or alcohol use in your family?	yes	no

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FEE AGREEMENT

STANDARD FEE FOR SERVICES

I understand that the standard fee for services for individual, couple, and family psychotherapy is $135.00 per 50-minute session or $202.50 per 80-minute session. The fee for group counseling is $50.00 per session. Other services are also available and these services and their associated fees are posted on the website or provided upon request.

A fee will be charged for all other auxiliary services including mental health evaluations, progress reports, collateral contacts, or any other report or services made at the request of the client. Fees for auxiliary services will be agreed upon prior to commencement of such services. Also, a fee will be charged at the session rate on a pro-rated basis for phone calls longer than ten (10) minutes. Any court testimony or appearances will be charged at a rate of $500 per hour.

Your fee/co-payment is due in full at each session. Have your cash or pre-written check ready prior to the beginning of each session. I understand that if I am in a position to pay the standard fee for services, that I will do so. This enables *Insight Counseling Center to* provide adjusted fees to others who aren't able to do so. I also understand that if my situation changes – at any point – that I am invited to re-negotiate this fee with my therapist. In other words, at no time should my decision to participate in therapy be contingent on my ability to pay. I understand that unless another payment schedule is specifically arranged, the standard fee for services applies. Any revisions to these standard fees for services are indicated on the reverse.

PAYMENT AGREEMENT

I understand that if I am paying privately I will pay for all services provided either for myself or for my designee, (name) _____, (relationship) _____, at the conclusion of each session on the day the services are provided.

I understand that if I am not able to honor my financial commitment that this may be grounds for conversing therapeutically about financial issues, renegotiating my therapeutic contract, exploring alternative options, and/or terminating from treatment. I understand that if I am not able to make a payment after a particular session that I may ask my therapist for an extension for another week. I agree to make every effort to remit payment within that time frame. I also understand that I may not have more than two unpaid sessions accumulated at any one time. If this should happen I understand that I will need to speak with my therapist in order to negotiate the next steps.

I understand that I may pay with cash, personal checks, or money orders, however, should my personal check be returned due to insufficient funds, I will be assessed a $25.00 service charge and I will be requested to pay with cash, or money order thereafter. I realize that while my signature does not bind me to therapy, it does make me responsible for all charges incurred prior to my termination. Finally, I release *Insight Counseling Center* and my therapist from all liability for providing to a Collection Agency any information necessary to collect fees due if my account becomes delinquent and that should this happen, the cost for collection will become my responsibility.

MISSED SESSION POLICY

I understand that I will be charged $70 for any missed appointments or appointments cancelled with less than 24 hours notice with NO EXCEPTIONS. I further understand that most third party payment sources, such as victim compensation funds and insurance companies, do not pay for missed sessions and thus I am solely responsible for these fees.

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LIMITATIONS OF CONFIDENTIALITY

I understand that if I am providing payment for a non-minor designee, I may not have legal access to any kind of privileged information about that individual including assessment information, diagnostic information, or therapeutic progress. By contrast, I do understand that if another party, such as an insurance company, is providing payment for my therapeutic services, I authorize that individual or institution to be informed of my presence in treatment, details of my diagnoses and care, and/or my discharge from treatment. I also understand that there are further limitations to confidentiality discussed in the *Practice Disclosure or* other agreements and am aware of these constraints.

USING INSURANCE OR THIRD PARTY PAYMENT SOURCES

I understand that in general, *Insight Counseling Center encourages* me to be personally responsible to my therapist for paying my fees at the time of service. In so doing, I recognize that I am actively participating and investing in the therapeutic process and am able to maintain a direct relationship with this investment. At the same time, I understand that *Insight Counseling Center* recognizes that I may wish to use an in or out-of-network insurance plan, EAP program, Health Savings Account, cafeteria plan, victim compensation program, or other such third party payer. If I should choose to use a third party payment source, I understand that I am still responsible for direct payment to *Insight Counseling Center* and that no guarantees can be made in terms of my reimbursement by the third party payment source. *Insight Counseling Center* will work with me as much as possible to facilitate this process.

I understand that if I use insurance or another type of third party payment source that I authorize *Insight Counseling Center* to release and/or exchange any pertinent information with such entities in order to utilize these benefits. This information includes but is not limited to my presence in treatment, my progress in treatment, my psychiatric diagnosis, any assessment information, and my discharge plan. I understand that most third party payment sources, such as insurance companies, do not pay for missed sessions and thus I am solely responsible for these fees.

REVISIONS TO FEE SCHEDULE

I understand that if I am committed to starting counseling at *Insight Counseling Center* and am not able to pay the full standard fee, my therapist will work with me on finding an adjusted fee that reflects both my value (as an individual, couple, or family) and my life circumstance. I understand that *Insight Counseling Center* is committed to making its services accessible to anyone who really wants them and will not turn anyone away simply because they are not able to pay the standard fee. I also understand that if my financial situation changes that I will let my therapist know so that my adjusted fee can be re-negotiated.

FEE SCHEDULE ADJUSTMENTS

The following reflects the adjusted fee schedule I have made with my therapist based on a therapeutic conversation about the value I put on these services and my present life situation:

$_____ Fee for Individual Psychotherapy, Couple, or Family Therapy
$_____ Fee for Group Psychotherapy
$_____ Other: _____

I have read the preceding information and I agree to the aforementioned terms:

Client Name: _____
Client Signature: _____ Date: _____
Therapist Name: _____
Therapist Signature:_____ Date: _____

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NOTICE OF PRIVACY PRACTICES
OF
Insight Counseling Center

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
Effective April 14, 2003

If you have any questions or requests about this Notice, please contact Beth Barta at 303.246.3219.

Insight Counseling Center is required by State and Federal law to maintain the privacy of protected health information. In addition, the Practice is required by law to provide clients with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to your mental health information, and to request that you sign the attached written acknowledgement that you received a copy of this Notice. This Notice describes how the Practice may use and disclose your protected health information. This Notice also describes your rights regarding your protected health information and how you may exercise your rights.

"Protected Health Information, PHI", is information the Practice has created or received about your physical or mental health condition, the health care we provide to you, or the payment for your health care; and identifies you or could be reasonably used to identify you. It includes your identity, diagnosis, dates of service, treatment plan, and progress in treatment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Permissible Uses and Disclosures Not Requiring Your Written Authorization Your mental health information may be used and disclosed in the following ways.

- **Treatment:** Your mental health information may be used and disclosed in the provision and coordination of your healthcare. For example, this may include coordinating and managing your health care with other health care professionals. Your mental health information may be used and disclosed when I consult with another professional colleague, or if you are referred for medication, or for coverage arrangements during my absence. In any of these instances only information necessary to complete the task will be provided.
- **Payment:** Your mental health care information will be used to develop accounts receivable information, to bill you, and with your consent to provide information to your insurance company or other third party payer for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, dates and type of service, and other information about your condition and treatment, but will be limited to the least amount necessary for the purposes of the disclosure.
- **Health Care Operations:** Your mental health information may be used and disclosed in connection with our health care operations, including quality improvement activities, training programs and obtaining legal services. Only necessary information will be used or disclosed.
- **Required or Permitted by Law:** Your mental health care information may be used or disclosed when I am required or permitted to do so by law or for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or to take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when a coroner is investigating the client's death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.
- **Contacting the Client:** You may be contacted to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.
- **Crimes on the premises or observed by the provider:** Crimes that are observed by the therapist or the therapist's staff, crimes that are directed toward the therapist or the therapist's staff, or crimes that occur on the premises will be reported to law enforcement.
- **Business Associates:** Some of the functions of the practice may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.
- **Involuntary Clients:** Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.
- **Family Members:** Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be

provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of the discussion. However, if the client objects, protected health information will not be disclosed.

- **Emergencies:** In life threatening emergencies the practice will disclose information necessary to avoid serious harm or death.

Uses and Disclosures Requiring Your Written Authorization or Release of Information
Except as described above, or as permitted by law, other uses and disclosures of your mental health information will be made only with your written authorization to release the information. When you sign a written authorization, you may later revoke the authorization in writing as provided by law. However, that revocation may not be effective for actions already taken under the original authorization.

- **Psychotherapy Notes:** Psychotherapy notes are maintained separate from your mental health record. These notes will be used only by your therapist and disclosure will occur only under these circumstances: (a) you specifically authorize their use or disclosure in a separate written authorization; or (b) the therapist who wrote the notes uses them for your treatment; or (c) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; or (d) if you bring a legal action and we have to defend ourselves; and (e) certain limited circumstances defined by the law.

YOUR RIGHTS AS A CLIENT

Additional Restrictions: You have the right to request additional restrictions on the use or disclosure of your mental health information. However, the clinician does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. Ask your clinician for the Request Form for Protected Health Information.

Alternative Means of Receiving Confidential Communications: You have the right to request that you receive communications from the practice by alternative means or at alternative locations. For example, you may request that bills and other correspondence be sent to an address other than your home address. Ask your clinician for the Request Form.

Access to Protected Health Information: You have the right to inspect and obtain a copy of your protected health information in the mental health and billing record. However, any psychotherapy notes are for the use of your therapist, and are treated differently. If it is thought that access to your mental health records would harm you, your access may be restricted. Ask your clinician for the Request Form for PHI and the appeal process.

Amendment of Your Record: You have the right to request an amendment or correction to your protected health information. If the clinician agrees that the amendment or correction is appropriate, the Practice will ensure the amendment or correction is attached to the record. An appeal process is available if the clinician determines the record is accurate and complete as is. Ask your clinician for the Request Form PHI and the appeal process available to you.

Accounting of Disclosures: You have the right to receive an accounting of certain disclosures the practice has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures authorized by you, or disclosures made prior to April 14, 2003. Other exceptions will be provided to you, should you request an accounting. Ask your clinician for the Request Form.

Right to Revoke Consent or Authorization: You have the right to revoke your consent or authorization to use or disclose your mental health information, except for action that has already taken place under your consent or authorization.

Copy of this Notice: You have a right to obtain a copy of this Notice upon request.

The Practice is required to abide by the terms of this Notice, or any amended Notice that may follow. The Practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. When changes are made, the revised Notice will be posted at the Practice's office and copies will be available upon request.

If you believe the Practice has violated your privacy rights, you may file a complaint to Beth Barta. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington, D.C. 20201. It is the policy of the Practice that there will be no retaliation for your filing of such a complaint.