CABOT psychological services

7301 Ohms Lane #450
Edina, MN 55439

Phone: 952.831.2000
Fax: 952.835.6134
cabotpsychologicalservices.com

Notice of Privacy Practices (Brief Version)

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.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please ask us if you want a copy of the longer version—it is also on our website. Feel free to talk to us about any questions or problems.

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.

2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact us to arrange how to see your records.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to us. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from an employee of Cabot Psychological Services.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact us.

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CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking of drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Permission for use granted by Richard Brown, MD.

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Client Information Form

Today's date: _____

Note: If you have been a client here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: ____

Preferred name and pronouns: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

Insurance company: _____ ID #: _____ Group #: _____ Copay: _____

B. **Referral:** Who gave you our name?

Name: _____ Phone: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

C. Religious and racial/ethnic identification

Current religious denomination/affiliation (if important to you): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Ethnicity/national origin: _____ Race: _____

Gender identity: _____

D. **Your medical care:** From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

May I coordinate care with your medical doctor? ❑ Yes ❑ No

E. Your current employer

Employer: _____ Address: _____

Work phone: _____

Calls will be discreet, but please indicate any restrictions: _____

F. Emergency information

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?
Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

G. Your education and training

Dates	Schools	Special classes? Adjustment to school? Did you graduate?

H. Employment and/or military experiences

Dates	Name of employers	Job title or duties	Reason for leaving

I. Family-of-origin history

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Brothers					
Sisters					
Stepparents					
Grandparents					

Uncles/aunts

Others

J. Marital/relationship history

	Spouse's name	Spouse's age at marriage	Your age at marriage	Has spouse remarried? Divorced/widowed
First				
Second				
Third				

K. Significant nonmarital relationships

	Name of other person	Person's age when started	Your age when started	Reasons for ending relationship
First				
Second				
Third				
Current				

L. Children

Indicate those from a previous marriage or relationship with "P" in the last column.

Name	Age	Sex/Gender	Grade	Adjustment problems?	P?

M. Is there any other information you think I should know?

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This document is an inclusive document consenting to various aspects of your treatment at Cabot Psychological Services (Cabot). Please carefully read and initial after each section, if you consent. Your signature at the end indicates that you have read and agree to every section in this document. Please speak to your therapist or staff at Cabot if you have any questions.

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.
I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.
I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)
I know that I **must cancel an appointment at least 24 hours (1 day) before the time** of the appointment. If I do not cancel and do not show up, I will be charged a fee of $100 for that missed appointment. This fee is not covered by insurance.
I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My initials here show that I understand and agree with all of the statements in the preceding section: ____

Consent to Use and Disclose Your Health Information

This form is an agreement between you and your therapist. When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, we will contact you.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to us. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

My initials here show that I understand and agree with all of the statements in the preceding section: ____

Agreement to Pay for Professional Services

I request that my therapist at Cabot provide professional services to me, and I agree to pay this therapist's fee of $175 per session ($250 for intake interview) for these services, or ensure that my insurance company is providing appropriate reimbursement for services rendered.

I agree that my financial relationship with this therapist will continue as long as the therapist provides services or until I inform them, in person or by writing, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me, although other persons or insurance companies may make payments on my account.

My initials here show that I understand and agree with all of the statements in the preceding section: ____

Credit Card Payment Consent Form

Cabot Psychological Services, PLLC (CPS) requires all clients to have a valid credit card on file prior to any sessions being held.

We require your credit card information for several reasons:

1. If you miss more than one appointment without calling 24 hours in advance, we charge your card the missed appointment fee of $100.00 (plus fees). This fee cannot be submitted to insurance.
2. In the event that you have an outstanding balance past 90 days, we will notify you via phone call and/or email that your card will be charged for the outstanding balance if you do not call to make partial or full arrangements for payment.
3. If you have co-pays or are paying out-of-pocket, we can keep your credit card information on file and charge it at the time of each session. This is optional.

As part of this service, our credit card providers charge CPS a service fee on each transaction. This additional fee is passed on to you as part of the payment and is covered by this signed consent form. The

2013 Minnesota Statutes related to credit card fees are printed on the back of this document. CPS does not generate any profit from the charging of this fee.

The per-charge fee is as follows:

- **3.15% + 15¢**

No fee is charged for clients who wish to pay off their balance in cash or via standard check.

I authorize CPS to keep my signature on file and to charge my Visa, Mastercard, American Express or Discover account for recurring charges of $100.00 (plus fees) for any missed appointment in which I have not called 24 hours in advance to cancel and for any outstanding balances past 90 days. I realize I will only be charged for outstanding balances past 90 days if I have not made any payment arrangements with the billing department.

I understand this form is valid unless I cancel the authorization in writing. I promise not to dispute charges ("charge back") for sessions I have received or that I have not cancelled 24 hours prior to a scheduled session. I further authorize CPS to disclose information about my attendance/cancellation to my credit card issuer if I dispute the charge.

If you have any questions, please consult with your clinician prior to signing this document.

My initials here show that I understand and agree with all of the statements in the preceding section: ____

Electronic Records Disclosure

"Policymakers in Minnesota have recognized that more effective use of health information technology, including timely exchange of information, is needed to improve quality and safety of care as well as to help control costs. In 2007, Minnesota enacted legislation that requires all health care providers in the state to implement an interoperable electronic EHR system by January 1, 2015 (Minn. Stat. §62J.495)." From the Minnesota State website

In keeping with the above mandate, Cabot Psychological Services (CABOT) keeps and stores records for each client in a record-keeping system produced and maintained by SimplePractice. This system is "cloud-based," meaning the records are stored on servers which are connected to the Internet. Here are the ways in which the security of these records is maintained:

- CABOT has entered into a HIPAA Business Associate Agreement with SimplePractice. Because of this agreement, SimplePractice is obligated by federal law to protect these records from unauthorized use or disclosure.
- The computers on which these records are stored are kept in secure data centers, where various physical security measures are used to maintain the protection of the computers from physical access by unauthorized persons.
- SimplePractice employs various technical security measures to maintain the protection of these records from unauthorized use or disclosure.
    - With data security and fill HIPAA compliance as top priorities, the team at SimplePractice partnered with cloud services provider, 7 Medical Systems, to host SimplePractice on HIPAA compliant, SSAE16 audited servers.
- CABOT has its own security measures for protecting the devices that we use to access these records:

- On computers, we employ firewalls, antivirus software, passwords, and disk encryption to protect the computer from unauthorized access and thus to protect the records from unauthorized access.

Here are things to keep in mind about CABOT's record-keeping system:

- While CABOT's record-keeping company and CABOT both use security measures to protect these records, their security cannot be guaranteed.
- Some workforce members at SimplePractice, such as engineers or administrators, may have the ability to access these records for the purpose of maintaining the system itself. As a HIPAA Business Associate, SimplePractice is obligated by law to train their staff on the proper maintenance of confidential records and to prevent misuse or unauthorized disclosure of these records. This protection cannot be guaranteed, however.
- CABOT's record-keeping company keeps a log of our transactions with the system for various purposes, including maintaining the integrity of the records and allowing for security audits. These transactions are kept for six years.

I understand that CABOT will be storing some of my personal health information (PHI) on a cloud-based system, maintained by SimplePractice EHR. I understand the advantages and potential risks associated with this system, and I have been given an opportunity to ask any questions about the process and system. I authorize CABOT to use this system to keep and store my health record.

My initials here show that I understand and agree with all of the statements in the preceding section: ____

Authorization to Electronically Communicate Protected Health Information

By filling out the below form, you are authorizing Cabot Psychological Services, PLLC (CPS) to send you future correspondence regarding your treatment via email or text. Your authorization does not obligate CPS to communicate by email/text or cease non-electronic communication.

Authorize email/text communication:

- ☐ I authorize the CPS staff to email/text me regarding the course of my treatment, billing, scheduling and any other related issues.

Patient's email address (please print): _____

Patient's text number (please print): _____

Discontinue email or text communication

- ☐ I no longer wish to communicate via email.
- ☐ I no longer with to communicate via text.

By signing this document, agree to the following:

- I understand that any email/text transmission between my provider and me/the patient will become part of my medical record. These email/text transmissions may be disclosed in accordance with future authorizations.
- I understand that I have the right to revoke this authorization at any time by indicating so above. If I want to revoke this authorization, I must do so in writing and address it to the entity that I had previously authorized to disclose my information. I understand that if I

revoke this authorization, it will not apply to any information already released as a result of this authorization.

- I understand that this authorization is voluntary and that I may refuse to sign it. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment if I refuse to sign this authorization.
- I understand that, once information is disclosed pursuant to this authorization, it is possible that it could be disclosed by the entity that receives it for authorized purposes under the HIPAA privacy rule.

Alert for Electronic Communication
Patients and/or personal representatives who want to communicate with their health care providers by email/text should consider all of the following issues before signing an authorization to Electronically Communicate Protected Health Information:

1. Email/text at CPS can be forwarded, intercepted, printed and stored by others.
2. Email/text communication is a convenience and is not appropriate for emergencies or time-sensitive issues**.**
3. Highly sensitive or personal information should only be communicated by email/text at the patient's discretion (i.e., HIV status, mental illness, chemical dependency, and workers compensation claims).
4. Employers generally have the right to access any email received or sent by a person at work.
5. Staff other than the health care provider may read and process email/text.
6. Clinically relevant messages and responses will be documented in the medical record at the provider's discretion.
7. Communication guidelines must be defined between the clinician and the patient, including (1) how often email/text will be checked, (2) instructions for when and how to escalate to phone calls and office visits, and (3) types of transactions that are appropriate for email/text.
8. Email message content must include (1) the subject of the message in the subject line (i.e., prescription refill, appointment request, etc.) and (2) clear patient identification such as patient name in the body of the message.
9. CPS will not be liable for information lost or misdirected due to technical errors or failures.

I have read and understand that email/text messages may include protected health information about me/the patient, whenever necessary.

My initials here show that I understand and agree with all of the statements in the preceding section: ____

My signature below shows that I understand and agree with all of the statements in this document.

_____
Signature of client (or person acting for client) Date

_____
Printed name Relationship to client (if necessary)

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INFORMATION FOR CLIENTS

Welcome to my practice. I appreciate your giving me the opportunity to be of help to you. This handout answers questions that clients often ask about therapy. I believe our work will be most helpful to you when you have a clear idea of what we are trying to do.

This handout talks about the following:

- The risks and benefits of therapy.
- The goals of therapy and my methods of treatment.
- Duration of therapy
- Cost of services, and how I handle financial matters.
- Other important areas of our relationship.

After you read this handout, we can talk in person about how these issues apply to you.

This handout is yours to keep. Please read all of it and mark any parts that are unclear. Write down any questions you have, and we will discuss them at our next meeting. When you have read and fully understood this handout, I will ask you to sign it at the end. I will sign it as well and make a copy, so we each have one.

About Psychotherapy

I strongly believe you should feel comfortable with the psychologist you choose, and hopeful about therapy. When you feel this way, therapy is more likely to be helpful to you. Let me describe how I see therapy:

My theoretical approach is based on empirically-supported treatment and clinical experience. I am an Acceptance and Commitment Therapy (ACT) clinician, and I will talk a lot about mindfulness and emotional tolerance. I think it's extremely important to recognize our internal processes (thoughts and feelings), acknowledge them without judgment and focus on changing our behavior to align with our individual value systems. As we do this, we often find that our thoughts and feelings become more tolerable and more adaptive to our situations. I also will try to get an idea about the maladaptive patterns that may have developed throughout childhood and been carried into adulthood. I use insight-oriented therapy to help you attain a better understanding of how you might have gotten to this point, and then help you make changes, as

you deem necessary. I am a firm believer in the power of our minds, and I know that changing our perceptions can affect our lives in profound ways.

The most central ideas in my work are the importance of the therapeutic relationship and the individual nature of each client. The same technique will not work for every person, so I tailor my treatment according to what you need. In order to do this, I ask and expect open communication from you about your thoughts and feelings regarding the work we are doing. With this collaborative approach, both of us should feel satisfied about the direction your therapy is going. Part of this approach entails you feeling comfortable with me. If you feel like our relationship does not encourage a feeling of safety and authenticity, I may not be the right psychologist for you. If you feel like our relationship gets in the way of your personal growth, it is your right, and even your responsibility, to end therapy.

The goals of my treatment are to make you a more insightful, self-aware individual. Of course, I also want you to feel better when you end therapy than when you began. This does not mean that you will leave each therapy session feeling better than when you arrived. Sometimes the work we do will be difficult and uncomfortable. Many times, it is crucial to explore uncomfortable emotions and thoughts in order to get to a place of better mental health.

I usually take notes during our first meeting. You may find it useful to take your own notes, and also to take notes outside the office. You could also tape-record our meetings to review at your leisure at home.

By the end of our first or second session, I will tell you how I see your case at this point and how I think we should proceed. As mentioned, I view therapy as a partnership between us. You define the problem areas to be worked on; I use some special knowledge to help you make the changes you want to make. Psychotherapy is not like visiting a medical doctor. It requires your very active involvement. It requires your best efforts to change thoughts, feelings, and especially behaviors. For example, I want you to tell me about important experiences, what they mean to you, and what strong feelings are involved. This is one of the ways you are an active partner in therapy.

I expect us to plan our work together. In our treatment plan we will list the areas to work on, our goals, the methods we will use, the time and financial commitments we will make, etc. I expect us to agree on a plan that we will both work to follow. From time to time, we will look together at our progress and goals. If we think we need to, we can then change our treatment plan, its goals, or its methods.

An important part of your therapy will be practicing new skills that you will learn in our sessions. I will ask you to practice outside our meetings, and we will work together to set up homework assignments for you. I might ask you to do exercises, keep records, or read to deepen your learning. You will probably have to work on relationships in your life and make long-term efforts to get the best results. These are important parts of personal change. Change will sometimes be easy and quick, but more often it will be slow and frustrating, and you will need to keep trying. There are no instant, painless cures and no "magic pills." However, you can learn new ways of looking at your problems that will be very helpful for changing your feelings and reactions.

Most of my clients see me once a week for 3 to 4 months. After that, we might meet less often for several more months. Therapy then usually comes to an end. The process of ending therapy, called "termination," can be a very valuable part of our work. Stopping therapy should not be done casually, although either of us may decide to end it if we believe it is in your best interest. If you wish to stop therapy at any time, I ask that you agree now to meet then for at least one more session to review our work together. We will review our goals, the work we have done, any future work that needs to be done, and our choices. If you would like to take a "time-out" from therapy to try it on your own, we should discuss this. We can often make such a "time-out" be more helpful.

The Benefits and Risks of Therapy

As with any powerful treatment, there are some risks as well as many benefits with therapy. You should think about both the benefits and risks when making any treatment decisions. For example, in therapy, there is a risk that clients will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other negative feelings. Clients may recall unpleasant memories. These feelings or memories may bother a client at work or in school. In addition, some people in the community may mistakenly view anyone in therapy as weak, or perhaps as disturbed or even dangerous. Also, clients in therapy may have problems with people important to them. Family secrets may be told. Therapy may disrupt a marital relationship and sometimes may even lead to a divorce. Sometimes, too, a client's problems may temporarily worsen after the beginning of treatment. Most of these risks are to be expected when people are making important changes in their lives. Finally, even with our best efforts, there is a risk that therapy may not work out well for you.

While you consider these risks, you should know also that the benefits of therapy have been demonstrated by scientists in hundreds of well-designed research studies. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. In therapy, people have a chance to talk things out fully until their feelings are relieved or the problems are solved. Clients' relationships and coping skills may improve greatly. They may get more satisfaction out of social and family relationships. Their personal goals and values may become clearer. They may grow in many directions—as persons, in their close relationships, in their work or schooling, and in the ability to enjoy their lives. I do not take on clients I do not think I can help. Therefore, I will enter our relationship with optimism about our progress.

Consultations

If you could benefit from a treatment I cannot provide, I will help you to get it. You have a right to ask me about such other treatments, their risks, and their benefits. Based on what I learn about your problems, I may recommend a medical exam or use of medication. If I do this, I will fully discuss my reasons with you, so that you can decide what is best. If you are treated by another professional, I will coordinate my services with them and with your own medical doctor.

If, for some reason, treatment is not going well, I might suggest you see another psychologist or another
professional for an evaluation. As a responsible person and ethical psychologist, I cannot continue to treat you if my treatment is not working for you. If you wish for another professional's opinion at any time, or wish to talk with another psychologist, I will help you find a qualified person and will provide him or her with the information needed.

What to Expect from Our Relationship

As a professional, I will use my best knowledge and skills to help you. This includes following the standards of the American Psychological Association, or APA. In your best interests, the APA puts limits on the relationship between a psychologist and a client, and I will abide by these. Let me explain these limits, so you will not think they are personal responses to you.

First, I am licensed and trained to practice psychology—not law, medicine, finance, or any other profession. I am not able to give you good advice from these other professional viewpoints.

Second, state laws and the rules of the APA require me to keep what you tell me confidential (that is, just between us). You can trust me not to tell anyone else what you tell me, except in

certain limited situations. I explain what those are in the “About Confidentiality” section of this handout. Here I want to explain that I try not to reveal who my clients are. This is part of my effort to maintain your privacy. If we meet on the street or socially, I may not say hello or talk to you very much. My behavior will not be a personal reaction to you, but a way to maintain the confidentiality of our relationship.

Third, in your best interest, and following the APA’s standards, I can only be your psychologist. I cannot have any other role in your life. I cannot be a close friend to or socialize with any of my clients. I cannot be a psychologist to someone who is already a friend. I can never have a sexual or romantic relationship with any client during, or after, the course of therapy. I cannot have a business relationship with any of my clients, other than the therapy relationship.

If you ever become involved in a divorce or custody dispute, I want you to understand and agree that I will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons: (1) My statements will be seen as biased in your favor because we have a therapy relationship; and (2) the testimony might affect our therapy relationship, and I must put this relationship first.

Even though you might invite me, I will not attend your family gatherings, such as parties or weddings.

As your psychologist, I will not celebrate holidays or give you gifts; I may not notice or recall your birthday; and may not receive any of your gifts eagerly. You should never feel obligated to bring me gifts for any reason, as our relationship is client-centered (it’s your time, not mine!).

About Confidentiality

I will treat with great care all the information you share with me. It is your legal right that our sessions and my records about you be kept private. That is why I ask you to sign a release form before I can talk about you or send my records about you to anyone else. In general, I will tell no one what you tell me. I will not even reveal that you are receiving treatment from me. In all but a few rare situations, your confidentiality is protected by federal and state laws and by the rules of my profession. Here are the most common cases in which confidentiality is not protected:

1. If you were sent to me by a court or an employer for evaluation or treatment, the court or employer expects a report from me. If this is your situation, please talk with me before you tell

me anything you do not want the court or your employer to know. You have a right to tell me only what you are comfortable with telling.

2. Are you suing someone or being sued? Are you being charged with a crime? If so, and you tell the court that you are seeing me, I may then be ordered to show the court my records. Please consult your lawyer about these issues.

3. If you make a serious threat to harm yourself or another person, the law requires me to try to protect you or that other person. This usually means telling others about the threat. I cannot promise never to tell others about threats you make.

4. If I believe a child or a vulnerable adult has been or will be abused or neglected, I am legally required to report this to the authorities.

There are two situations in which I might talk about part of your case with another psychologist. I ask now for your understanding and agreement to let me do so in these two situations.

First, when I am away from the office for a few days, I may have a trusted fellow psychologist cover for me. This psychologist will be available to you in emergencies. Therefore, he or she needs to know about you. Of course, this psychologist is bound by the same laws and rules as I am to protect your confidentiality.

Second, I sometimes consult other psychologists or other professionals about my clients. This helps me in giving high-quality treatment. These persons are also required to keep your information private. Your name will never be given to them, some information will be changed or omitted, and they will be told only as much as they need to know to understand your situation.

It may be beneficial for me to confer with your primary care physician with regard to your psychological treatment or to discuss any medical problems for which you are receiving treatment. In addition, Medicare requires that I notify your physician by telephone or in writing, concerning services that are being provided by me unless you request that notification not be made.

Please check only ONE of the following:

❑ You are authorized to contact my primary care physician whose name and address are shown below to discuss the treatment that I am receiving while under your care and to obtain information concerning my medical diagnosis and treatment.

❑ I do not authorize you to contact my primary care physician with regard to the treatment that I am receiving while under your care or to obtain information concerning my medical diagnosis and treatment. I am providing you with the name and address of my primary care physician only for your records.

Please write below the name, address, and phone number of your primary physician:

_____
_____
Name Phone

_____
_
Address

On occasion, I may want to make audio recordings of our sessions. I will ask your permission to make any recording. I promise to destroy each recording as soon as I no longer need it, or at the latest, when I destroy your case records. You can refuse to allow this recording, or can insist that the recording be edited.

Except for situations like those I have described above, I will always maintain your privacy. I also ask you not to disclose the name or identity of any other client being seen in this office.

If your records need to be seen by another professional, or anyone else, I will discuss it with you. If you agree to share these records, you will need to sign an authorization form. This form states exactly what information is to be shared, with whom, and why, and it also sets time limits. You may read this form at any time. If you have questions, please ask me.

It is my office policy to destroy clients' records 7 years after the end of our therapy. Until then, I will keep your case records in a safe place.

If I must discontinue our relationship because of illness, disability, or other presently unforeseen circumstances, I ask you to agree to my transferring your records to another psychologist who will assure their confidentiality, preservation, and appropriate access.

As part of cost control efforts, an insurance company will sometimes ask for more information on symptoms, diagnoses, and my treatment methods. It will become part of your permanent medical record. I will let you know if this should occur and what the company has asked for.

Please understand that I have no control over how these records are handled at the insurance company. My policy is to provide only as much information as the insurance company will need to pay your benefits.

You can review your own records in my files at any time. You may add to them or correct them, and you can have copies of them. I ask you to understand and agree that you may not examine records created by anyone else and then sent to me.

In some very rare situations, I may temporarily remove parts of your records before you see them. This would happen if I believe that the information will be harmful to you, but I will discuss this with you.

You have the right to ask that your information not be shared with family members or others, and I can agree to that limitation. You can also tell me if you want me to send mail or phone you at a more private address or number than, say, your home or workplace. If this is of concern to you, please tell me so that we can make arrangements.

My Background

I am a licensed clinical psychologist with several years of experience. I worked for five years at Hennepin County Medical Center, first as a predoctoral intern, then as a postdoctoral fellow, and finally as a senior clinical psychologist. I also worked at The Emily Program, conducting therapy with outpatients who struggle with eating disorders. I am trained and experienced in doing individual, group and couples therapy with adults (18 years and over). Earlier in my training, I worked in university clinics, a prison and other settings. I hold these qualifications:

- I have a doctoral degree in clinical psychology from Auburn University, whose program is approved by the American Psychological Association (APA).
- I completed a one-year, APA-accredited internship in clinical psychology at Hennepin County Medical Center (HCMC). I also did my post-doctoral fellowship at HCMC.
- I am licensed as a psychologist in Minnesota.

About Our Appointments

The very first time I meet with you, we will need to give each other much basic information. Following this, we will usually meet for approximately 55 minutes, leaving the remaining minutes of the hour for me to complete paperwork and billing. We can schedule meetings for

both your and my convenience. I will tell you as far in advance as possible of my vacations or any other times we cannot meet.

An appointment is a commitment to our work. We agree to meet here and to be on time. If I am ever unable to start on time, I ask for your understanding. I also assure you that you will receive the full time agreed to. If you are late, we will probably be unable to meet for the full time, because it is likely that I will have another appointment after yours. A cancelled appointment delays our work. I consider our meetings very important and ask you to do the same. Please try not to miss sessions if you can possibly help it. When you must cancel, please give me at least two days' notice. Your session time is reserved for you. I am rarely able to fill a cancelled session unless I know a week in advance. If you miss sessions without notifying me 24 hours in advance, I will have to charge you for the lost time. Your insurance will not cover this charge. Except for unpredictable emergencies (or because of a situation that would be seen by both of us as an unpredictable emergency), I will charge you at least 50% of the regular fee for any missed sessions, or those cancelled with less than 24 hours' notice.

I request that you do not bring children with you if they are young and need babysitting or supervision, which I cannot provide.

You will be charged for any damage to, or theft of, property in this office by you or anyone for whom you are legally responsible.

I cannot be responsible for any personal property or valuables you bring into this office.

Fees, Payments, and Billing

Payment for services is an important part of any professional relationship. This is very true in therapy; one treatment goal is to make relationships and the duties and obligations they involve clear. You are responsible for seeing that my services are paid for. Meeting this responsibility shows your commitment and maturity.

My current regular fees are as follows. You will be given advance notice if my fees should change.

Intake sessions: $250. Sixty-minute therapy sessions: $175. Please pay your part of each session at its beginning or end. I have found that this arrangement helps us stay focused on our goals. It also allows me to keep my fees as low as possible, because it cuts down on my bookkeeping

costs. I suggest you make out your check before each session begins, so that our time will be used best. Other payment or fee arrangements must be worked out before the end of our first meeting.

Telephone consultations: I believe that telephone consultations may be suitable or even needed at times in our therapy. If so, I will charge you our regular fee, prorated over the time needed. If I need to have long telephone conferences with other professionals as part of your treatment, you will be billed for these at the same rate as for regular therapy services. If you are concerned about all this, please be sure to discuss it with me in advance so we can set a policy that is comfortable for both of us. Of course, there is no charge for calls about appointments or similar business.

Reports: I will not charge you for my time spent making routine reports to your insurance company. However, I will have to bill you for any extra-long or complex reports the company might require. The company will not cover this fee.

Other services:

I realize that my fees involve a substantial amount of money, although they are well in line with similar professionals' charges. For you to get the best value for your money, we must work hard and well.

I will assume that our agreed-upon fee-paying relationship will continue as long as I provide services to you. I will assume this until you tell me in person, by telephone, or by certified mail that you wish to end it. You have a responsibility to pay for any services you receive before you end the relationship.

Because I expect all payment at the time of our meetings, I usually do not send bills. However, if we have agreed that I will bill you, I ask that the bill be paid within two weeks of when you get it.

As needed, but not less than once a year, I will give you a statement. The statement can be used for health insurance claims, if necessary. It will show all of our meetings, the charges for each, how much has been paid, and how much (if any) is still owed. At the end of treatment, and when you have paid for all sessions, I will send you a final statement for your tax records.

Depending on your financial circumstances and total medical costs for any year, psychotherapy may be a deductible expense; consult your tax advisor. Cost of transportation to and from appointments and fees paid may be deductible from the client's personal income taxes as medical expenses.

If you think you may have trouble paying your bills on time, please discuss this with me. I will also raise the matter with you so we can arrive at a solution. If your unpaid balance reaches $100, I will notify you by mail. If it then remains unpaid, I must stop therapy with you. Fees that continue unpaid after this may be turned over to small-claims court or a collection service.

A late fee of 1½% of the unpaid balance will be charged each month.
A late payment fee of $10 will be charged each month that a balance remains unpaid.

If there is any problem with my charges, my billing, your insurance, or any other money-related point, please bring it to my attention. I will do the same with you. Such problems can interfere greatly with our work. They must be worked out openly and quickly.

If You Have Traditional (or "Indemnity") Health Insurance Coverage

Because I am a licensed psychologist, many health insurance plans will help you pay for therapy and other services I offer. Because health insurance is written by many different companies, I cannot tell you what your plan covers. Please read your plan's booklet under coverage for "Outpatient Psychotherapy" or under "Treatment of Mental and Nervous Conditions." Or call your employer's benefits office to find out what you need to know.

If your health insurance will pay part of my fee, I will file the insurance claims for you. However, please keep two things in mind:
1. I had no role in deciding what your insurance covers. Your employer decided which, if any, services will be covered and how much you have to pay. You are responsible for checking your insurance coverage, deductibles, payment rates, copayments, and so forth. Your insurance contract is between you and your company; it is not between me and the insurance company.
2. You—not your insurance company or any other person or company—are responsible for paying the fees we agree upon. If you ask me to bill a separated spouse, a relative, or an insurance company, and I do not receive payment on time, I will then expect this payment from you.

If You Have a Managed Care Contract

If you belong to a health maintenance organization (HMO) or preferred provider organization (PPO), or have another kind of health insurance with managed care, decisions about what kind of care you need and how much of it you can receive will be reviewed by the plan. The plan has rules, limits, and procedures that we should discuss. Please bring your health insurance plan's description of services to one of our early meetings, so that we can talk about it and decide what to do.

I will provide information about you to your insurance company only with your informed and written consent. I may send this information by mail or by fax. My office will try its best to maintain the privacy of your records, but I ask you not to hold me responsible for accidents or for anything that happens as a result.

If You Need to Contact Me

I cannot promise that I will be available at all times. Although I am in the office Monday through Friday, I do not take phone calls when I am with a client. You can always leave a message on my voicemail, and I will return your call as soon as I can. Generally, I will return messages daily except on weekends and holidays.

If you have an emergency or crisis, please try to contact me. If you have a behavioral or emotional crisis and cannot reach me immediately by telephone, you or your family members should call one of the following community emergency agencies: the Acute Psychiatric Services (APS) at Hennepin County Medical Center (HCMC) at 612-873-3161, or the Crisis Connection at 612-379-6363. If you are unable to find help, call 911.

If I Need to Contact Someone about You

If there is an emergency during our work together, or I become concerned about your personal safety, I am required by law and by the rules of my profession to contact someone close to you—perhaps a relative, spouse, or close friend. I am also required to contact this person, or the authorities, if I become concerned about you harming someone else. Please write down the name and information of your chosen contact person in the blanks provided:
Name: _____
Address:_____
___
Phone: _____

Relationship to you: _____

Statement of Principles and Complaint Procedures

It is my intention to fully abide by all the rules of the American Psychological Association (APA) and by those of my state license.

Problems can arise in our relationship, just as in any other relationship. If you are not satisfied with any area of our work, please raise your concerns with me at once. Our work together will be slower and harder if your concerns with me are not worked out. I will make every effort to hear any complaints you have and to seek solutions to them. If you feel that I (or any other psychologist) have treated you unfairly or have even broken a professional rule, please tell me. You can also contact the state or local psychological association and speak to the chairperson of the ethics committee. He or she can help clarify your concerns or tell you how to file a complaint. You may also contact the Minnesota Board of Psychology, the organization that licenses those of us in the independent practice of psychology.

In my practice as a psychologist, I do not discriminate against clients because of any of these factors: age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. This is a personal commitment, as well as being required by federal, state, and local laws and regulations. I will always take steps to advance and support the values of equal opportunity, human dignity, and racial/ethnic/ cultural diversity. If you believe you have been discriminated against, please bring this matter to my attention immediately.

Our Agreement

I, the client (or his or her parent or guardian), understand I have the right not to sign this form. My signature below indicates that I have read and discussed this agreement; it does not indicate that I am waiving any of my rights. I understand that any of the points mentioned above can be discussed and may be open to change. If at any time during treatment I have questions about any of the subjects discussed in this handout, I can talk with you about them, and you will do your best to answer them. I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy with you.

I understand that no specific promises have been made to me by this psychologist about the results of treatment, the effectiveness of the procedures used by this psychologist, or the number of sessions necessary for therapy to be effective.

I have read, or have had read to me, the issues and points in this handout. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered in this handout. I hereby agree to enter into therapy with this psychologist (or to have the client enter therapy), and to cooperate fully and to the best of my ability, as shown by my signature here.

_____

_____

Signature of client (or person acting for client) Date

_____

Printed name

Relationship to client: ❑ Self ❑ Parent ❑ Legal guardian

❑ Health care custodial parent of a minor (less than 14 years of age)

❑ Other person authorized to act on behalf of the client - specify

Initial here to show that you have read this page.

I, the psychologist, have met with this client (and/or his or her parent or guardian) for a suitable period of time, and have informed him or her of the issues and points raised in this handout. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into therapy with the client, as shown by my signature here.

_____

_____

Signature of psychologist Date

I truly appreciate the chance you have given me to be of professional service to you, and look forward to a successful relationship with you. If you are satisfied with my services as we proceed, I (like any professional) would appreciate your referring other people to me who might also be able to make use of my services.

❑ Copy accepted by client ❑ Copy kept by psychologist

CABOT psychological services

7301 Ohms Lane #450
Edina, MN 55439

Phone: 952.831.2000
Fax: 952.835.6134
cabotpsychologicalservices.com

Notice of Privacy Practices

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.

Privacy is a very important concern for all those who come to this office. It is also complicated, because of the many federal and state laws and our professional ethics. Because the rules are so complicated, some parts of this notice are very detailed, and you probably will have to read them several times to understand them. If you have any questions, we will be happy to help you understand our procedures and your rights.

Contents of this notice

A. Introduction: To our clients

This notice will tell you how we handle your medical information. It tells how we use this information here in this office, how we share it with other professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family. If you have any questions or want to know more about anything in this notice, please ask us for more explanation or more details.

B. What we mean by your medical information

Each time you visit us or any doctor's office, hospital, clinic, or other health care provider, information is collected about you and your physical and mental health. It may be information about your past, present, or future health or conditions, or the tests and treatment you got from us or from others, or about payment for health care. The information we collect from you is called **"PHI,"** which stands for **"protected health information."** This information goes into your **medical or health care records** in our office.

In this office, your PHI is likely to include these kinds of information:

_ Your history: Things that happened to you as a child; your school and work experiences; your marriage and other personal history.

_ Reasons you came for treatment: Your problems, complaints, symptoms, or needs.

_ Diagnoses: These are the medical terms for your problems or symptoms.

_ A treatment plan: This is a list of the treatments and other services that we think will best help you.

_ Progress notes: Each time you come in, we write down some things about how you are doing, what we notice about you, and what you tell us.

_ Records we get from others who treated you or evaluated you.

_ Psychological test scores, school records, and other reports.

_ Information about medications you took or are taking.

_ Legal matters.

_ Billing and insurance information

There may also be other kinds of information that go into your health care records here.

We use PHI for many purposes. For example, we may use it:

_ To plan your care and treatment.

_ To decide how well our treatments are working for you.

_ When we talk with other health care professionals who are also treating you, such as your family doctor or the professional who referred you to us.

_ To show that you actually received services from us, which we billed to you or to your health insurance company.

_ For teaching and training other health care professionals.

_ For medical or psychological research.

_ For public health officials trying to improve health care in this area of the country.

_ To improve the way we do our job by measuring the results of our work.

When you understand what is in your record and what it is use d for, you can make better decisions about who, when, and why others should have this information.

Although your health care records in our office are our physical property, the information belongs to you. You can read your records, and if you want a copy we can make one for you (but we may charge you for the costs of copying and mailing, if you want it mailed to you). In some very rare situations, you cannot see all of what is in your records. If you find anything in your records that you think is incorrect or believe that something important is missing, you can ask us to amend (add information to) your records, although in some rare situations we don't have to agree to do that. If you want, we can explain more about this.

C. Privacy and the laws about privacy

We are required to tell you about privacy because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires us to keep your PHI private and to give you this notice about our legal duties and our privacy practices. We will obey the rules described in this notice. If we change our privacy practices, they will apply to all the PHI we keep. We will also post the new notice of privacy practices in our office where everyone can see. You or anyone else can also get a copy from our privacy officer at any time. It is also posted on our website at www.cabotpsychservices.com and at www.dramandamulfinger.com.

D. How your protected health information can be used and shared

Except in some special circumstances, when we use your PHI in this office or disclose it to others, we share only the **minimum necessary** PHI needed for those other people to do their jobs. The law gives you rights to know about your PHI, to know how it is used, and to have a say in how it is shared. So we will tell you more about what we do with your information.

Mainly, we will use and disclose your PHI for routine purposes to provide for your care, and we will explain more about these below. For other uses, we must tell you about them and ask you to sign a written authorization form. However, the law also says that there are some uses and disclosures that don't need your consent or authorization.

1. Uses and disclosures with your consent

After you have read this notice, you will be asked to sign a separate **consent form** to allow us to use and share your PHI. In almost all cases we intend to use your PHI here or share it with other people or organizations to provide treatment to you, arrange for payment for our services, or some other business functions called "health care operations." In other words, we need information about you and your condition to provide care to you. You have to

agree to let us collect the information, use it, and share it to care for you properly. Therefore, you must sign the consent form before we begin to treat you. If you do not agree and consent we cannot treat you.

a. The basic uses and disclosure: For treatment, payment, and health care operations
Next we will tell you more about how your information will be used for treatment, payment, and health care operations.

For treatment. We use your medical information to provide you with psychological treatments or services. These might include individual, family, or group therapy; psychological, educational, or vocational testing; treatment planning; or measuring the benefits of our services.

We may share your PHI with others who provide treatment to you. We are likely to share your information with your personal physician. If you are being treated by a team, we can share some of your PHI with the team members, so that the services you receive will work best together. The other professionals treating you will also enter their findings, the actions they took, and their plans into your medical record, so we all can decide what treatments work best for you and make up a treatment plan. We may refer you to other professionals or consultants for services we cannot provide. When we do this, we need to tell them things about you and your conditions. We will get back their findings and opinions, and those will go into your records here. If you receive treatment in the future from other professionals, we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment.

For payment. We may use your information to bill you, your insurance, or others, so we can be paid for the treatments we provide to you. we may contact your insurance company to find out exactly what your insurance covers. We may have to tell them about your diagnoses, what treatments you have received, and the changes we expect in your conditions. We will need to tell them about when we met, your progress, and other similar things.

For health care operations. Using or disclosing your PHI for health care operations goes beyond our care and your payment. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to supply some information to some government health agencies, so they can study disorders and treatment and make plans for services that are needed. If we do, your name and personal information will be removed from what we send.

b. Other uses and disclosures in health care
Appointment reminders. We may use and disclose your PHI to reschedule or remind you of appointments for treatment or other care. If you want us to call or write to you only at your home or your work, or you prefer some other way to reach you, we usually can arrange that. Just tell us.

Treatment alternatives. We may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of help to you.

*Other benefits and services. W*e may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Research. We may use or share your PHI to do research to improve treatments—for example, comparing two treatments for the same disorder, to see which works better or faster or costs less. In all cases, your name, address, and other personal information will be removed from the information given to researchers. If they need to know who you are, we will discuss the research project with you, and we will not send any information unless you sign a special authorization form.

Business associates. We hire other businesses to do some jobs for us. In the law, they are called our "business associates." Examples may include a copy service to make copies of your health records, and a billing service to figure out, print, and mail our bills. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy, they have agreed in their contract with us to safeguard your information.

2. Uses and disclosures that require your authorization

If we want to use your information for any purpose besides those described above, we need your permission on an **authorization form.** We don't expect to need this very often. If you do allow us to use or disclose your PHI, you can cancel that permission in writing at any time. We would then stop using or disclosing your information for that purpose. Of course, we cannot take back any information we have already disclosed or used with your permission.

3. Uses and disclosures that don't require your consent or authorization

The law lets us use and disclose some of your PHI without your consent or authorization in some cases. Here are some examples of when we might do this.

a. When required by law

There are some federal, state, or local laws that require us to disclose PHI:

_ We have to report suspected child abuse. If you are involved in a lawsuit or legal proceeding, and we receive a subpoena, discovery request, or other lawful process we may have to release some of your PHI. We will only do so after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information they requested.

_ We have to disclose some information to the government agencies that check on us to see that we are obeying the privacy laws.

b. For law enforcement purposes

I may release medical information if asked to do so by a law enforcement official to investigate a crime or criminal.

c. For public health activities

I may disclose some of your PHI to agencies that investigate diseases or injuries.

d. Relating to decedents
I may disclose PHI to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants.

e. For specific government functions
We may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment. We may disclose your PHI to workers' compensation and disability programs, to correctional facilities if you are an inmate, or to other government agencies for national security reasons.

f. To prevent a serious threat to health or safety
If we come to believe that there is a serious threat to your health or safety, or that of another person or the public, we can disclose some of your PHI. We will only do this to persons who can prevent the danger.

4. Uses and disclosures where you have an opportunity to object
We can share some information about you with your family or close others. We will only share information with those involved in your care and anyone else you choose, such as close friends or clergy. We will ask you which persons you want us to tell, and what information you want us to tell them, about your condition or treatment. You can tell us what you want, and we will honor your wishes as long as it is not against the law.

If it is an emergency, and so we cannot ask if you disagree, we can share information if we believe that it is what you would have wanted and if we believe it will help you if we do share it. If we do share information, in an emergency, we will tell you as soon as we can. If you don't approve we will stop, as long as it is not against the law.

5. An accounting of disclosures we have made
When we disclose your PHI, we may keep some records of whom we sent it to, when we sent it, and what we sent. You can get an accounting (a list) of many of these disclosures.

E. Your rights concerning your health information
1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or with payment for your care, such as family members and friends. We don't have to agree to your request, but if we do agree, we will honor it except when it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you. Contact an employee to arrange how to see your records.

4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to us. You must also tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this notice, we will post the new one in our waiting area, and you can always get a copy from us.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

You may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

F. If you have questions or problems

If you need more information or have questions about the privacy practices described above, please speak to us. If you have a problem with how your PHI has been handled, or if you believe your privacy rights have been violated, contact us. As stated above, you have the right to file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services. We promise that we will not in any way limit your care here or take any actions against you if you complain. If you have any questions or problems about this notice or our health information privacy policies, please contact us.

The effective date of this notice is February 1, 2024.