The New Beginnings Center
Counseling and Integrative Health Since 1982

Susan Richter, MFT, CEDS, SEP
License #MFT19108
dba The New Beginnings Center

Welcome!

Please complete and sign the attached forms. You will be provided a copy of the information for your personal files.

Feel free to ask me any questions you may have regarding this information. To make the most use of our time together, please have your payment ready at the start of each session. Payment can be made with cash, check or credit card through PayPal. Checks can be made payable to: Baker & Richter Psychotherapy.

Restrooms are located outside our suite to the right. The keys are hanging underneath the counter on the left side of the reception area. Please make yourself comfortable, enjoy some water or tea if you wish, and I will be with you shortly.

I look forward to meeting with you.

Sincerely,

Susan Richter

Susan Richter, MFT, CEDS, SEP

155 Granada Street, Ste N
Camarillo, CA 93010

info@thenewbeginningscenter.com
www.thenewbeginningscenter.com

Phone (805) 987-3162
Fax (805) 715-4483

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INTAKE INFORMATION

Date ___/___/___

Client _____

Address _____

_____

Email: _____

Occupation _____

Who Referred You? _____

Physician _____

Who referred you? _____

Date of Birth ___/___/___

*Gender Identity*_____

Relationship Status: _____

Primary Phone #: _____

Work Phone #: _____

Date of Last Physical ___/___/___

Physician Phone _____

Previous Psychotherapy? Yes No

If yes, When? _____ *With Whom?* _____

Any Major Illness _____

Current Medications _____

*Emergency contact: Name*_____ *Phone #*_____

FAMILY MEMBERS:

Name	*Date of Birth*	*Relationship*	*Living at home?*
_____	___/___/___	_____	*yes / no*
_____	___/___/___	_____	*yes / no*
_____	___/___/___	_____	*yes / no*
_____	___/___/___	_____	*yes / no*
_____	___/___/___	_____	*yes / no*
_____	___/___/___	_____	*yes / no*

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INTAKE INFORMATION

For Insurance Users Only
(Please present insurance card)

PRIMARY INSURANCE _____

Insured _____ Gender: Female Male

Address _____

_____

Authorization No. _____

Relationship to client: Self Spouse Other _____

Insured Date of Birth _____

SECONDARY INSURANCE _____

Insured _____ Gender: Female Male

Address _____

_____

Authorization No. _____

Relationship to client: Self Spouse Other _____

Insured Date of Birth _____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature _____ Date _____

I authorize payment of medical benefits to the undersigned physician or supplier for services described on claims.

Signature _____ Date _____

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SYMPTOM CHECKLIST

Date _____ Name _____ Age _____

For each of the following symptoms, please circle a number 0-5 for the difficulty you are having with each symptom, with 0 being no difficulty, 1 being little and 5 being severe difficulty. Please answer every question.

1. Briefly describe the traumatic event(s): _____
   _____
   _____
   _____
   _____
   Date of event(s) _____
2. Feelings of helplessness and/or powerlessness 0 1 2 3 4 5
3. Lack of focus 0 1 2 3 4 5
4. Gaps in memory 0 1 2 3 4 5
5. Disorientation 0 1 2 3 4 5
6. Accident proneness 0 1 2 3 4 5
7. Feeling out of control 0 1 2 3 4 5
8. Feeling frozen or paralyzed 0 1 2 3 4 5
9. Recurring dreams related to traumatic event 0 1 2 3 4 5
10. Intrusive imagery related to traumatic event 0 1 2 3 4 5
11. Flashbacks 0 1 2 3 4 5
12. Disrupted sleeping patterns 0 1 2 3 4 5

Circle one: insomnia oversleeping both

13. Lethargy, exhaustion, chronic fatigue 0 1 2 3 4 5
14. Night terrors or abrupt awakening with intense fear 0 1 2 3 4 5
15. Extreme emotional shifts 0 1 2 3 4 5
16. Rage 0 1 2 3 4 5
17. Over-cautiousness 0 1 2 3 4 5
18. Fear of being watched/followed 0 1 2 3 4 5
19. Heightened startle response 0 1 2 3 4 5
20. Feeling Overwhelmed 0 1 2 3 4 5
21. Feeling defeated, inadequate, can't do anything 0 1 2 3 4 5
22. Feeling confused or fragmented 0 1 2 3 4 5
23. Too much energy (hyperactivity 0 1 2 3 4 5
24. Impulses to run away 0 1 2 3 4 5
25. Unable to feel weight of body 0 1 2 3 4 5
26. Feeling physically heavy-like dead weight 0 1 2 3 4 5
27. Constricted range of motion 0 1 2 3 4 5
28. Feeling disconnected, lost, “not here” 0 1 2 3 4 5
29. Trouble orienting time 0 1 2 3 4 5
30. Trouble orienting space 0 1 2 3 4 5
31. Avoidance of triggers or associations with events 0 1 2 3 4 5
32. Panic attacks 0 1 2 3 4 5
33. Free-floating anxiety 0 1 2 3 4 5
34. Nausea or vomiting 0 1 2 3 4 5
35. Shame 0 1 2 3 4 5
36. Self judgment/blaming self 0 1 2 3 4 5
37. Electric or overcharged feeling in body 0 1 2 3 4 5
38. Obsessive review of incident 0 1 2 3 4 5
39. Disrupted eating pattern 0 1 2 3 4 5

Circle one: overeating under-eating both

40. Recurring tension patterns in body 0 1 2 3 4 5
41. Chronic pain 0 1 2 3 4 5
42. Hyper-vigilance 0 1 2 3 4 5
43. Inability to cope 0 1 2 3 4 5
44. Isolation 0 1 2 3 4 5
45. Constriction, suppression, shut down 0 1 2 3 4 5

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46. Distrust 0 1 2 3 4 5
47. Little or no awareness of choices 0 1 2 3 4 5
48. Disinterest in life 0 1 2 3 4 5
49. Generalized fear or anger(for example, believing *all* men, or *all* women are threatening, or *all* drivers are unsafe) 0 1 2 3 4 5
50. Excessive worrying 0 1 2 3 4 5
51. Disrupted relationships 0 1 2 3 4 5
52. Alienation, believing no one can understand 0 1 2 3 4 5
53. Bonding with others through trauma 0 1 2 3 4 5
54. Sudden fearfulness for no apparent reason 0 1 2 3 4 5
55. Fearlessness or dangerous situations 0 1 2 3 4 5
56. Temper or outbursts 0 1 2 3 4 5
57. Desire to hurt self or others 0 1 2 3 4 5
58. Loss of sexual interest 0 1 2 3 4 5
59. Dizziness 0 1 2 3 4 5
60. Idea that someone can control your thoughts 0 1 2 3 4 5
61. Fear of being alone 0 1 2 3 4 5
62. Fear of being with others 0 1 2 3 4 5
63. Crying easily 0 1 2 3 4 5
64. Inability to cry 0 1 2 3 4 5
65. Fear of leaving home or familiar surroundings 0 1 2 3 4 5
66. Adamant “everything fine” stance 0 1 2 3 4 5
67. No sense of future 0 1 2 3 4 5
68. Loss of creativity 0 1 2 3 4 5
69. Depression 0 1 2 3 4 5
70. Shakiness 0 1 2 3 4 5
71. Apathy, no energy for life 0 1 2 3 4 5
72. Feeling dead or in ”no man’s land" 0 1 2 3 4 5
73. Feeling blocked about finishing what you start 0 1 2 3 4 5
74. Starting many projects and not completing them 0 1 2 3 4 5
75. Hypersensitivity to sound or light 0 1 2 3 4 5
76. Get feelings hurt easily 0 1 2 3 4 5
77. Irritability, overreacting to things 0 1 2 3 4 5
78. Checking everything you do 0 1 2 3 4 5
79. Circle those that apply: Shouting, throwing objects, hitting or kicking, desire to have tantrum or scream 0 1 2 3 4 5
80. Everything seems too much trouble 0 1 2 3 4 5
81. Feeling wear in body, collapsed joints 0 1 2 3 4 5
82. Feeling doomed or as if something bad is going to happen 0 1 2 3 4 5
83. Restlessness 0 1 2 3 4 5
84. Heart pounding 0 1 2 3 4 5
85. Not remembering aspects of a traumatic event 0 1 2 3 4 5
86. Difficulty connecting or feeling close to others 0 1 2 3 4 5
87. Difficulty making decisions 0 1 2 3 4 5
88. Guilt 0 1 2 3 4 5
89. Numbing 0 1 2 3 4 5
90. Going blank 0 1 2 3 4 5
91. Feelings of worthlessness 0 1 2 3 4 5
92. Feeling your life was threatened during the traumatic event(s) 0 1 2 3 4 5
93. Feeling your life is in danger since the traumatic event(s) 0 1 2 3 4 5

PROFESSIONAL POLICIES
Susan Richter, LMFT, CEDS, SEP

Dear Clients:

Welcome! I would like to clearly communicate to you my policies about my psychotherapy practice. Your (or your family member's) participation in psychotherapy can result in many benefits to you. These may include a better understanding of your personal goals, values, thoughts, and feelings, as well as improved relationships, changed behavior, and resolution of the specific concerns that bring you here. This all requires effort on your part, which may also involve emotional discomfort. Change occurs differently and uniquely for each person, and is often slow and sometimes frustrating. There is, however, no guarantee that treatment will remove all emotional pain. I use many techniques as part of my practice, including: talking therapy, visualization exercises, hypnosis, Eye Movement Desensitization and Reprocessing (EMDR), art, Somatic Experiencing, and other standard psychotherapeutic methods. I welcome any questions you may have about the therapy process and practices, so please feel free to discuss these and any other questions with me.

When working with clients under the age of 18 years, **I must have the consent of all parents/guardians who hold "legal custody". I will not treat children without this written consent.** I prefer to involve all parents/guardians as much as is therapeutically appropriate. I will be glad to discuss how, when, and if this can be accomplished in your situation.

About My Practice

I provide services as a CA licensed MFT #19108, under a professional marriage and family therapy corporation *dba*The New Beginnings Center. In order to provide you with the best possible care, I will consult with my professional associates at The New Beginnings Center, whenever appropriate. I also utilize professional consultations in order to continually improve my psychotherapy skills. From time to time, I may share some information with these professionals about our conversations so that I may better serve you in our work together. These professionals must also abide by the ethical rules of confidentiality.

In our sessions together, we will spend a significant time talking with one another, exchanging ideas and perspectives. I shall want to know about you, to the degree that you are willing and able to share. A part of our work will involve me encouraging you to pay attention to those aspects of you that are beyond and beneath your words, namely your body, your senses, your feelings, and images. On occasion, and only with your agreement, I use Somatic Experiencing touch. Often the touch involves remaining in our chairs and experiencing 'grounded touch' like a foot touching a foot or a hand on a shoulder. I shall also always ask you permission before I place a hand on any area of your body.

Please sign here to verify that you have read and understood the above information.

Client(s) Signature _____ **Date** _____

Confidentiality and Limits of Confidentiality

All information between the client and the therapist is held in strict confidence. I am required by the Board of Behavioral Sciences to keep session notes, and if subpoenaed, I may be legally obligated to release client files. Disclosure may be required in the following circumstances:

a. When there is reasonable suspicion of child abuse or abuse to a dependent or elder adult.
b. When the client communicates a threat of bodily injury to others.
c. When the client is suicidal.
d. If the client authorizes by signing a release of information form.
e. When disclosure is required pursuant to a legal proceeding.

Therapy Time and Standard Fee

1. Sessions are generally 45 minutes in length.
2. If you need to cancel a session, **please remember I require 24 hour notice.** You can leave a message on my voice mail 24 hours a day, 7 days a week. Otherwise, you will be charged for your missed session (charged to you, not your insurance company for the FULL fee).
3. If you are late, we will meet for the remainder of your scheduled session. If you are more than 20 minutes late and I have not heard from you, I will assume you aren't coming and may leave the office.
4. Telephone time is limited to 5-10 minutes, beyond which I will bill you at my standard rate at 15 minute intervals. Payment will be expected at the next regularly scheduled appointment, or sooner by mail.

_____(Initial)

Accessibility and Emergencies:

I use a voicemail system which can be accessed by you 24 hours a day, 7 days a week. I check my messages frequently during normal business days/hours. In case of a crisis or urgent situation, you may contact another member of your treatment team at The New Beginnings Center at (805) 987-3162, or other agencies/authorities equipped to deal with serious emergencies. A crisis is a situation in which you feel you are in danger of being emotionally overwhelmed. If you have tried all your coping skills and they are not enough, and the situation cannot wait until your next appointment, please call.

Terminations:

Termination from therapy is an important process which can be of benefit to clients and therapists. This is an important opportunity to reflect on progress, or lack of, and the process of where you are now and where you hope to be going. I encourage my clients to partake with me in this process of finding out what was helpful and that could have been more helpful. It is your right to terminate therapy at any time. If you choose to terminate, I will be glad to provide referrals to qualified professionals. As your therapist, I have the right and duty to terminate therapy under the following circumstances: when I assess that treatment is no longer helpful or beneficial to you, if I determine that another professional would better serve your needs; if you have not paid for the last two sessions (unless a special arrangement has been made); or if you have failed to show up for your last two sessions without the required 24 hour notice of cancellation. In all cases I will be happy to provide you with the resources and referrals as necessary.

Financial Policies and Charges:

1. Fees can be paid in the following manner:
    a. You pay in full each session; you may send my bill to your insurance (does not apply to HMO and managed care). Please request a billing statement.
    b. You pay your assigned co-payment required by your insurance company or mental health benefits, I bill your insurance for the remaining balance (you may still be liable for balance if your insurance does not pay).
2. A physician referral may be required by your insurance company for mental health benefits. If required, please obtain this promptly as you will be responsible for all charges until you do.
3. I do not bill secondary insurance. I can, upon request, provide a billing statement which you can submit to your secondary carrier for reimbursements to you.
4. A charge will assessed for reports requested by the client(s) (for court, attorneys, work, etc.
5. A $25.00 late fee is assessed on overdue accounts for each month delinquent.

Please remember, **all charges are ultimately your responsibility**. It is your responsibility to maintain insurance coverage, update me regarding any changes and keep informed as to your deductibles or changes in co-payments.

Additional charges may be incurred for the following: letter writing at clients request, court reports or documentation requested by attorneys (authorized by the client), sessions which take place at someplace other than this office, special meetings. Time outside this office is usually charged door to door. Any additional charges will be discussed in advance

and agreed upon. I charge for extensive telephone calls (see above). These charges are calculated on my regular hourly fee and are not covered by insurance.

Technology/Social Media Policy:

In an age of fast changing technology it is important to understand the risks and benefits involved in any communication, especially of a private nature such as in therapy. I take reasonable steps to protect your privacy, however, it is important to understand and accept the risks to privacy by using these methods of communication. If you do NOT want me to contact you via email/text etc. please tell me. Please limit text or email communications to non-urgent matters that are not critical or private as there can be a delay in my receipt and/or response using such methods.

I have a Professional Facebook page: *Susan Richter, MFT, CEDS, SEP*. The purpose of this is to provide the general public with information that may benefit the community. However, you are welcome to view and "like" it if you wish to follow the posts. There is no confidentiality or privacy on Facebook; therefore this should not be considered an appropriate way to communicate with me and only used to view or share public information. I also do not accept personal friend or contact requests from current/ former clients on any social networking site. I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

If you have any questions about how best to communicate with me I encourage you to talk about it when we meet. Communication via technology should not be considered a substitute for face-to-face therapy communication. Please note that any communication between a client and therapist can be part of the clinical record.

Other Resources

I am available to share with you other resources including reading materials, service organizations, health practitioners, attorneys, educational support services, etc. Please feel free to ask for these resources with the knowledge that I cannot be held responsible for the quality of other professionals' services and that these professionals are not affiliated with me.

I have read, understand, and agree to the professional policy of Susan Richter, LMFT, CEDS, SEP.

Client(s) Signature _____ **Date** _____

Client(s) Signature _____ **Date** _____

Parent/Guardian Signature (if client is under 18 years of age)

_____ Date_____

Therapist's Signature_____ Date_____

PHI USE AND DISCLOSURE POLICY

1. Your client record or PHI (Personal Health Information) is confidential. Client information can only be released pursuant to a signed release, a court order, or if one of the exceptions to confidentiality discussed below applies. If you are in individual therapy and are an adult, I will generally not release any PHI except pursuant to your written authorization, a subpoena, a court order, or one of the exceptions to confidentiality discussed below. If you are in conjoint therapy, then I will not release information about any participant in therapy without the written consent of all the participants, unless one of the exceptions to confidentiality set out below applies.

   If a minor child is my client, generally I will require the signature of the parent or parents who have legal custody of the child. Depending on the child's age, I may also obtain a release from the child. If a minor's counsel has been appointed for the child, then under California Family Code §3151, only the minor's counsel can release the child's privilege. Under California Health and Safety Code §123115, I may withhold information or records if I determine producing them would have a detrimental effect on my relationship with the child or would have a detrimental effect on the child's physical safety or psychological wellbeing. In such a circumstance I will use my clinical judgment to protect your child's therapeutic interests.

2. If you have insurance which is being billed for our professional services, some information regarding you may be requested by the carrier. The amount of information varies depending upon the kind of plan you have. (HMOs for example often want periodic written reports and will contact the providers directly.) Insurance plans may make use of and/or require electronic communications by fax or computer. While I will make every reasonable effort in this office to protect your privacy, I have no control of, and am not responsible for, any problems which occur once the information has left our office. If you have any questions about this or your particular insurance plan, please contact me to discuss it.

3. In most instances I use a laptop computer to store most clinical files. This computer is protected by encryption software, password, and several levels of passcodes and has a regular backup procedure. I do not allow third parties to have access to this computer. In addition, I maintain some patient files in locked storage cabinets.

4. I am legally required to protect the privacy of your PHI which includes information which includes information that can be used to identify you that I have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment for this healthcare. I am required to provide you with this notice about my privacy practices which explains how, when and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, and analyze such information within my practice. A disclosure of PHI happens when it is released, transferred, is given to or is otherwise divulged to a third party who is outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is reasonably necessary to accomplish the purpose for which the use or disclosure is made.

   I am legally required to follow the privacy practices described in this notice.

5. I reserve the right to change the terms of this notice and my privacy policies at any time and any such changes will apply to PHI which is on file with me already. If I change this notice, I will post a new one in my office. You can request a copy of this notice from me if you like.

6. I keep treatment notes in client files. These are generally not disclosed directly to clients in order to protect the emotionally charged nature of such. A summary can be provided, or with client authorization these can be shared with a qualified medical or psychological professional deemed by the client and/or legal representative.

6 .A. USES AND DISCLOSURES OF PHI THAT DON'T REQUIRE YOUR CONSENT

Uses and disclosures relating to treatment, payment or healthcare operations do not require your prior written consent. I can use and disclose your PHI without your consent for the following reasons:

1) **For treatment**. I can disclose your PHI to licensed health care providers who provide you with healthcare services or involved in your care. For example, if you are being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care. However, I would not be able to disclose your PHI to a healthcare provider who is not involved in providing care to you.
2) **To obtain payment for treatment**. I can use and disclose your PHI to bill and collect payment for treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to either get paid for the health care services or have you reimburse for health care services that I have provided to you. I may also provide your PHI to my business associates such as billing companies or others that help process my claims for care provided to you.
3) **For health care operations.** I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of another health care professional who provided services to you in our office. I may also provide your PHI to our accountants, attorneys, or consultants to make sure that I am complying with the laws that are applicable.
4) **Other disclosures**. I may also disclose your PHI to others without your consent in certain situations. For example, if you need emergency treatment or you're unable to communicate with me due to being unconscious or severe pain and I think it is likely that you would consent to treatment if you were able to do so.

6. B. USE AND DISCLOSURES THAT DO NOT REQUIRE YOUR CONSENT

There are certain circumstances where I can use and disclose your PHI without your consent because of federal or state law which authorizes such disclosures to be made or requires them to be made.

1) **Child or elder abuse reporting**. If you report information to me that gives me a reasonable suspicion that child abuse, elder abuse or abuse of a dependent adult has occurred, then I am required by law to report such abuse to the appropriate governmental agency. This reporting will be by telephone and in writing and, in addition, I may be required to have discussions with government employees who are investigating the abuse report.
2) **Threats.** If you make a threat that I believe to be a serious threat of bodily harm or death to another person, or if I am advised that you have made such a threat by a member of your family or a significant other, I am required by law to notify the person who you have expressed the threat regarding and law enforcement.
3) **Danger to Self.** If I determine that you pose an imminent risk of harm to yourself, I may disclose information to the necessary authorities to try and protect you from harming yourself.
4) **Subpoenas.** If I receive a subpoena from a Federal or State court or an administrative agency concerning you, then I may be required to disclose PHI in response to the subpoena. If I do receive such a subpoena, I will make reasonable efforts to notify you in advance to discuss it. Under California law, if a subpoena is served for psychotherapy records, the person issuing the subpoena is required to give you notice that your records are being sought and you have the opportunity to both object, and file a motion to prevent the disclosure. The issuance of a subpoena by itself is not sufficient to compel me to disclose information about you without your consent. Of course, if you choose to consent to comply with the subpoena and provide me with an appropriate written release, I will comply with the subpoena.
5) **Minors.** As noted above with regards to patients who are minors, generally the consent of both parents will be required before I can release information, records or testify. In some instances, the court will have appointed a minor's counsel who by operation of law is the sole person who can make decisions on the child's privilege.
6) **Health oversight activities.** I may have to provide information to governmental agencies when conducting an investigation or inspection of health care provider organization.
7) **For specific government functions.** I may disclose PHI of military personnel and veterans in certain situations as required by law. I may disclose PHI for national security purposes such as protecting the President of the United States or conducting intelligence operations.

8) **For workers compensation purposes.** I may provide PHI in order to comply with Workers Compensation laws and orders from the Workers Compensation Appeals Board.

9) **Appointment reminders and health related benefits of services.** I may use PHI to provide appointment reminders or give you information about treatment alternatives or other health care services or benefits I offer.

6. C. USES AND DISCLOSURES WHICH REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT

I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care unless you object in full or in part. The opportunity to consent may be obtained retroactivity in an emergency situation.

6. D. MINIMUM NECESSARY DISCLOSURES

When using or disclosing PHI and was requesting PHI from another therapist, hospital or facility, I will make reasonable efforts to use, disclosure or request the minimum amount of PHI reasonably necessary to accomplish the intended purpose of the use, disclosure, or request.However, among the uses, disclosures and requests, which the minimum necessary standard does not apply to, are:

1) Disclosures to a request by a healthcare provider for treatment purposes;
2) Disclosures to you as the patient who is the subject of the information
3) Uses or disclosures made pursuant to a valid authorization signed by you
4) Uses or disclosures that are required for compliance with the HIPPA privacy standards;
5) Disclosures to the Department of Health and Human Services when required by them for compliance and enforcement purposes; and
6) Uses or disclosures that are otherwise required by law.

7. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. **The right to request limits on uses and disclosures of your PHI.** You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures in ways that prevent me from doing things I am legally required to do or allowed to do.

B. **The right to choose how I send PHI to you.** You have the right to ask that I send information to you at an alternate address. For example, sending information to your work address rather than your home address or by alternate means. For example, email instead of regular mail. I must agree with your request as long as I can easily provide the PHI to you in the format you requested.

C. **The right to see and get copies of your PHI.** In most cases, you have the right to look at or get copies of your PHI that I have but you must make the request in writing. Depending on whether your request is made under federal or state law, the length of time in which I have to respond will vary. I will respond to you within the period of time the law allows me to respond. In some situations, I may be required and in use of my clinical judgment, to deny your request. If I do, I will explain in writing my reasons for the denial and your right to have my denial reviewed. The amount of costs you can be charged for copying a PHI is governed by different statutes and I will charge you the statutorily set rate for such copies. I may elect to provide you with a summary or explanation of the PHI.

D. **The right to get a list of disclosures I have made.** You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to such as those made for treatment, payment or health care operations, directly to you or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel. I will respond to your request for an accounting of disclosures within 60

days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of disclosure, to whom PHI was disclosed, including their address if known, a description of the information disclosed and the reason for the disclosure. I will provide the list to you at no charge but if you make more than one request in the same year, I will charge you a reasonable cost for the additional request.

E. **The right to correct or update your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to update or correct information. You must provide the request and the reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing. PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my record. My written denial will state the reason for the denial; explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request at your request to my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, will you I have done it, and tell others that need to know about the change to your PHI.

F. **The right to get this notice by email.** You have the right to get a copy this notice by email. Even if you have agreed to receive notice by email, you also have the right to request a paper copy of it.

G. **How to complain about my privacy practices.** If you think I may have violated your privacy rights or you disagree with the decision I have made about access to your PHI, you may file a complaint with the Secretary of the Department of Health and Human Services at 200 Independence Avenue, Southwest Washington D.C. 20201. I will not take any retaliatory action against you if you file a complaint about my privacy practice.

H. **Notification of breach of unsecured PHI.** You will receive notification of any breach of unsecured PHI.

I. **Clients have the right** to restrict disclosures of PHI to health plans for certain payment or health care operations purposes, assuming the PHI pertains solely to a health care item or service that clients have paid for out-of-pocket in full.

J. **PHI will not be sold** without client authorization.

K. **PHI will not** be disclosed for marketing purposes.

8. PATIENT CONSENT and/or Parent/Guardian Signature(s) ****ALL* **LEGAL PARENTS MUST SIGN***

I consent to the use or disclosure of my protected health information by Susan Richter, MFT, CEDS, SEP, for the purpose of diagnosing or providing services to me and/or my child, obtaining payment for my health care bills, or to conduct health operations of The New Beginnings Center.

Client(s) Signature _____ **Date** _____

Client(s) Signature _____ **Date** _____

Parent/Guardian Signature (if client is under 18 years of age)

_____ **Date** _____

_____ **Date** _____