REGISTRATION FORM

(please complete, sign and return all pages)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If couples therapy, enter name of either spouse/partner)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

House Number Street City State Zip Code

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications/Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If couples therapy, enter name of other spouse/partner)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

House Number Street City State Zip Code

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications/Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications/Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Financially Responsible For This Account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL AND PRIVACY POLICIES AND PRACTICES**

Dr. Alan Zwerdling’s practice maintains the following financial and privacy policies. I understand and agree to these policies, as follows:

**Payment and Non-Participation with Insurance**: Payment in full for all professional services rendered is due at the time of service. Dr. Zwerdling does not participate with any insurance plans or networks. I am personally responsible for payment for all fees for professional services rendered. Upon my request, I will be provided with a written statement which I can submit to my health insurance company for coverage, provided I have benefits which cover “out of network” providers for the specific services rendered. Dr. Zwerdling makes no claim as to whether my health insurance company will reimburse me for his services, and I agree to hold him harmless should no insurance reimbursement be received.

**Direct and Indirect Hourly Fees:** Regular hourly fees will be charged for all direct and indirect clinical work. Direct work includes all face to face contact with patients and family members. Indirect work includes consultation with schools, physicians, attorneys or other parties as requested or agreed upon, paperwork such as composing letters, reports, evaluations, disability claims, and so on, and telephone calls with patients or other parties on behalf of the patient. Indirect services are not covered by insurance plans and payment in full will be my personal responsibility.

**Cancellations:** I understand that time is reserved for me when I schedule an appointment. If it is necessary to cancel an appointment, at least 48 hours notice of cancellation must be provided to avoid being charged. All cancellation of appointments must be conducted by telephone or email only. Text communication is not available. I agree to be personally responsible for payment of the regular hourly fee for all broken or cancelled appointments unless a full 48 hour notice is provided by telephone.

**Email Communication:** I understand that email communication may not be secure and therefore confidentiality of emails cannot be guaranteed. Should I choose to communicate or request communication by email it is with the informed consent that such contact may not be private and confidential and I agree to hold Dr. Zwerdling harmless in that event.

**Receipt of Notice of Privacy Practices**: I hereby acknowledge that I have received a Notice of Privacy Practices (HIPAA) and have been provided ample opportunity for review and discussion.

**Overdue Accounts and Collections:** I understand that if my account is overdue by 30 days or longer Dr. Zwerdling has the right to pursue collections of my balance to the full extent of the law, and will release personal information toward that end.

**Couples Therapy Privacy Agreement:** Information disclosed in couples/family therapy is for therapeutic purposes only and is not intended for use in any legal proceedings involving myself or my partner. In order for the therapy experience to be as safe as possible, I agree that I will not request that Dr. Zwerdling release any information or impressions about either myself or my partner in writing or orally, and I agree that I will not subpoena Dr. Zwerdling to release information or to testify for or against myself or my partner in any court action. I agree that all individual sessions conducted by Dr. Zwerdling with myself or my partner as a component of couples therapy will be transparent; information will not be kept confidential from my partner, and Dr. Zwerdling reserves the right to share all information with my partner at his discretion in an effort to further therapeutic goals. I agree to hold Dr. Zwerdling harmless in that event. This agreement will continue and survive beyond the termination of therapy.

**Emergencies: In case of an emergency requiring immediate attention, go directly to your local hospital emergency room or use your phone to dial 911 for help. Dr. Zwerdling does not provide emergency service and does not check phone calls after hours.**

I hereby certify that the above registration information is true, and agree to notify Dr. Zwerdling of any changes. I understand and agree to the financial and privacy policies and practices detailed above. I hereby assign directly to Dr. Alan Zwerdling all medical benefits, if any, otherwise payable to me for any services rendered. I hereby authorize Dr. Alan Zwerdling to release all information necessary for submitting claims and securing benefits on behalf of myself and/or dependents, if applicable. I hereby authorize the use of this signature on insurance submissions on behalf of myself and/or dependents, if applicable.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TELETHERAPY INFORMED CONSENT ADDENDUM (If Applicable)**

I hereby consent to engage in teletherapy with Dr. Alan Zwerdling, PhD. I understand that “teletherapy” includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental health information, both orally and visually. I understand that I have the following rights and responsibilities with respect to teletherapy:

**Licensure**: I understand that Dr. Zwerdling is licensed only in the state of New Jersey and as such, can only provide teletherapy to residents of New Jersey. I attest that I am a resident of New Jersey.

**Confidentiality**: The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my teletherapy is strictly confidential. In general, no information will be released to anyone without my prior written approval. However, the law requires Dr. Zwerdling to release information without my approval under the following circumstances: he suspects the threat of serious or foreseeable harm to myself or others; he suspects the abuse, neglect or exploitation of a child, elderly or disabled person; there is a court order requiring the release of information.

**Recording**: I understand and agree that neither Dr. Zwerdling nor myself will record our teletherapy sessions without the permission of all involved parties.

**Electronic Risks**: I understand that while all possible precautions are being taken by Dr. Zwerdling to ensure my privacy and confidentiality, there are inherent risks when using online technology for teletherapy, including, but not limited to: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

**Safety Plan: I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I agree to call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24 hour hotline support.**

**Session Interruption**: If a teletherapy session should shut down, Dr. Zwerdling will attempt to start a new meeting immediately. If technological issues prevent the meeting from restarting, I will call Dr. Zwerdling immediately to continue the session by phone. Should a disruption occur at a time of crisis or emergency, I agree to call 911 or go to my nearest emergency room immediately.

**Appropriateness of Teletherapy**: I understand that in certain circumstances Dr. Zwerdling may determine that teletherapy is no longer appropriate and may recommend in person sessions either with himself or another therapist.

**Technology Requirements & Security**: I understand that I am responsible for providing the necessary computer and webcam or smart phone and secure (non-public) internet access for my teletherapy sessions; the security of any information stored on my equipment; and arranging an appropriately private, well-lit location that is free from distractions for my teletherapy session.

**Insurance Coverage for Teletherapy**: I understand that it is my own responsibility to confirm with my insurance company that teletherapy will be reimbursed. I will be responsible for full payment for teletherapy services independent of my insurance coverage. I am personally responsible for all fees for professional services rendered which are due at the time of service.

**Access to Medical Records**: I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law. I also have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

**Financial and Privacy Practices and Policies**: I understand that this addendum is in addition to the “Financial and Privacy Practices and Policies” previously reviewed and agreed to.

**I have read, understand and agree to the information provided above regarding teletherapy.**

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CREDIT CARD CHARGE AUTHORIZATION**

I hereby authorize Dr. Alan Zwerdling to charge my debit card or credit card (Visa, Mastercard, American Express, Discover) for all professional services in person, by telephone, and/or via teletherapy, including failed appointments and appointments cancelled without 48 hours notice. A 3% processing fee will be added to all transactions.

Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Card (Visa/MC/Amex/Disc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Associated with Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

House Number Street

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

Name of Card Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA NOTICE OF PRIVACY PRACTICES**

(please review and keep for your records)

Notice of Psychologists’ Policies and Practices

to Protect the Privacy of Your Health Information

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

1. **Uses and Disclosures for Treatment, Payment, and Health Care Operations**

Psychologists may *use* or *disclose* your *protected health information* (*PHI*) for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

* *“PHI”* refers to information in your health record that could identify you.
* *“Treatment, Payment and Health Care Operations”:*

*-Treatment* is when a psychologist provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

- *Payment* is when a psychologist obtains reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for that care or to determine eligibility or coverage.

*- Health Care Operations* are activities that relate to the performance and operation of a psychologist’s practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

*“Use*” applies only to activities within a psychologist’s office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

*“Disclosure*” applies to activities outside of a psychologist’s office, such as releasing, transferring, or providing access to information about you to other parties.

1. **Uses and Disclosures Requiring Authorization**

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

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

1. **Uses and Disclosures with Neither Consent nor Authorization**

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

**Child Abuse:** If a psychologist has reasonable cause to suspect that a child has been subject to abuse by a parent, legal custodian, caregiver or any other person responsible for the child’s welfare, the law requires that the psychologist must immediately report this suspicion or knowledge to the New Jersey Division of Youth and Family Services.

**Adult and Domestic Abuse:** If a psychologist knows or has reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, a psychologist is required by law to immediately report such knowledge or suspicion to the county Adult Protective Services provider.

**Health Oversight:** If the New Jersey State Board of Psychological Examiners issues a subpoena, a psychologist may be compelled to testify before the Board and produce confidential records and papers if they are relevant to that complaint.

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

**Serious Threat to Health or Safety:** If you communicate to your psychologist a threat of imminent serious physical violence against a readily identifiable victim or yourself, and the psychologist believes you intend to carry out that threat, the psychologist must take steps to warn and protect. A psychologist must also take such steps if it is believed that you intend to carry out such violence, even if you have not made a specific verbal threat. These teps may include arranging for your admission to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of yourself and the intended victim, warning the intended victim or guardian, and warning your parent or guardian if you are under the age of 18 years old.

**Worker’s Compensation:** If you file a worker’s compensation claim, a psychologist must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider or the attorney for the employer or insurance carrier, furnish your relevant records to those persons. There may be additional disclosures of PHI required or permitted by law to make without your consent or authorization, including but not limited to medical and non-medical experts, the Division of Worker’s Compensation, and so on.

1. **Patient’s Rights and Psychologist’s Duties: Patient’s Rights**:

***Right to Request Restrictions*** *.* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, a psychologist is not required to agree to a restriction you request.

*Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* . You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.

*Right to Inspect and Copy*. You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in the mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, a psychologist will discuss with you the details of the request process.

***Right to Amend***. You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. A psychologist may deny your request. On your request the details of the amendment process will be discussed with you.

***Right to an Accounting***. You generally have the right to receive an accounting of disclosures of PHI regarding yourself. On your request, the details of the accounting process will be discussed with you.

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

**Patient’s Rights and Psychologist’s Duties: Psychologist’s Duties:**

Psychologists are required by law to maintain the privacy of PHI and to provide you with a notice of the psychologist’s legal duties and privacy practices with respect to PHI. Psychologists reserve the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, a psychologist is required to abide by the terms currently in effect. If a psychologist revises policies and practices such that a change to the notice is required, you will be provided with a revised notice of policies and practices in writing.

1. **Questions and Complaints**

If you have questions about this notice or have other concerns about your privacy rights, you may contact Dr. Alan Zwerdling, Ph.D. at (732) 936-1212 for further information.

If you believe that your privacy rights have been violated or you disagree with a decision made about access to your records, you may send your written complaint to Dr. Alan Zwerding, Ph.D. at the following address: 170 State Highway 35, Red Bank, NJ 07701. All complaints must be submitted in writing.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule, and there will be no retaliation against you for exercising your right to file a complaint.

1. **Effective Date, Restrictions and Changes to Privacy Policy**

This notice will go into effect on November 1st 2011. Dr. Alan Zwerdling, Ph.D. reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that he maintains. You will be provided with a copy of the revised notice.