Consents
Communication, Treatment, & Release of Information

Consent for Communication

I consent for J. Daniel Bruce LCSW to communicate with me by mail, email, and phone (voice or text) as noted, at the following addresses and phone numbers. I will IMMEDIATELY advise the therapist in the event of any change:

Name:_____

Address: _____City:_____Zip:_____

Phone: Home _____( ) please check if your preferred method of contact

Cell _____( ) please check if your preferred method of contact

Work _____( ) please check if your preferred method of contact

May I leave a message on your voicemail? Y N

Do you wish to receive and send texts? Y N

Email: _____( ) please check if your preferred method of contact

How did you hear about me? _____

If someone referred you to me, may I thank them? Y N

Consent to Treatment

I, the undersigned client, understand that I have the right not to sign this consent form. My signature below indicates that I have read and discussed this agreement. I voluntarily agree to receive mental health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, and services as are considered necessary and advisable.

I, understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned counselor at any time. However, premature termination may result in failure to achieve therapeutic outcomes.

By signing this Client Information and Consent Form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ _____

Client Signature **Date**

_____ _____

Spouse/Partner Power of Attorney Signature (if applicable) Date

_____ Initial Here

Consent for Release of Information/HIPPA Authorization Form

This form serves to authorize the release of information discussed during sessions if this information needs to be released to an outside party such as, but not limited to, a psychiatrist, or medical doctor. This form is not required for treatment but is the only form that will authorize J. Daniel Bruce, LCSW to speak with any individuals outside the therapy session.

_____ _____
Client name Date of birth

_____ _____
Client name Date of birth

I hereby authorize J. Daniel Bruce, LCSW to provide and/or receive information from:

_____
Name

_____
Address

_____
Phone number

Types of information to be disclosed (client should check all that apply):

___ Assessment/Diagnosis
___ Information
___ Educational Records
___ Special Education Records
___ Counseling Notes
___ Psychosocial Assessment
___ Continuing Care Plan
___ Psychological Evaluation
___ Treatment Update
___ Treatment Plan or Summary
___ Other _____

Revocation
You have the right to revoke this authorization, in writing, at any time by sending written notification to Elder Care Solution Services, J Daniel Bruce LCSW at the following address: 1701 W Northwest Hwy, ste 100, Grapevine, Texas 76051

A revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless earlier revoked, this authorization expires one (1) year from the start of therapy _____ (date), unless otherwise indicated.

_____ Initial Here

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, J. Daniel Bruce, LCSW reserves the right to communicate information as permitted by this authorization in any manner that she deems appropriate and consistent with applicable law, including but not limited to written, verbal, and/or electronic communications. I further waive and release J. Daniel Bruce, LCSW from any liability resulting in the release of the above information.

_____ _____
Client signature Date

_____ _____
Parent/Family Member Signature Date

_____ _____
Relationship to Client Date

_____ _____
Witness Signature Date

A photocopy of facsimile of this authorization is as valid as the original.

NOTICE OF RECIPIENT INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure on this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. DISCLAIMER: It is the legal responsibility of the recipient of this information (transmitted electronically or otherwise) to comply with HIPPA regulations.

_____ Initial Here

Cancellation/No-Show Policy

Cancellations

Cancellations must be received at least 24 hours before your scheduled appointment; otherwise you will be charged your full session fee for that missed appointment. You are responsible for calling to cancel or reschedule your appointment. The main number is (817) 300-4073 or by email info@ElderCareSolutionServices.com The reason for this is that when you make an appointment you are reserving a time. As your therapist, I have agreed not to utilize that time slot for any other purpose. If you fail to keep your appointment and fail to give adequate notice, I am unable to schedule another use for that part of my workday.

For this reason, I will ask for a credit/debit card to keep on file. You will be charged the full amount of your session fee at the time of the late cancellation/no-show.

By signing this document, you acknowledge that you have read, understand and agree to the terms and conditions contained in this document.

_____
Client Name (Printed)

_____
Client Signature Date

CREDIT CARD INFORMATION:
Purchasers Name: _____

Purchasers Address: _____

City State Zip

_____ ----_____--- _____
Credit Card Number Expiration CVV

PURCHASER SIGNATURE DATE

_____ _____

_____ Initial Here

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you have so we can discuss them during your initial meeting with me. When you sign this document, it will represent an agreement between us. Your ***initials*** on each page confirm that you have read and understand the provisions of that section of the contract.

PROFESSIONAL INFORMATION DISCLOSURE STATEMENT

What to expect from our relationship?
Therapy is a relationship that works in part because of clearly defined rights and responsibilities of each participant. These clearly defined roles and boundaries are what distinguish the professional client/therapist relationship from other types of relationships. It is these roles and boundaries that permit safe and effective exploration of important topics and themes in treatment. As a client receiving therapy, you have certain rights that are important for you to know about so that you can be an informed and active participant in your own treatment. There are also certain limitations to these rights that you need to know. As a therapist, I also have rights and responsibilities in providing treatment to you.

Be aware that therapy produces potential emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings, some of them painful at times. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful.

My Responsibilities to You as Your Therapist

I. Confidentiality

With the exception of certain specific exceptions described below, what you discuss in therapy is kept confidential. This means that I cannot tell anyone what you have told me during our sessions. This confidentiality also prohibits me from telling others that you are in treatment. I must have your written permission prior to making any form of disclosure about your treatment. In the event that you permit me to disclose information about your treatment, I will do so on a "need to know basis." This means that I will share the minimum amount of information needed in order to achieve the necessary outcome. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. If you revoke permission, please submit your request in writing and be aware that information already disclosed for the purposes of your treatment and with your permission cannot be rescinded and will only apply to future potential disclosures.

You are protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically, it will be done with special safeguards to insure confidentiality.

If you elect to communicate with me by email, video session or text at some point in our work together, please be aware that neither is completely confidential. All emails are retained in the logs of an internet service provider and texts could be accessed through the cell provider. While under typical circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service or cell service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record. Texts are deleted after messages are received. My cell number is my contact number and it is only used in my practice.

Our relationship is professional. It is important not to have any relationship outside counseling sessions, such as a friendship, business, or a social relationship. If we have contact in a public setting, I will not acknowledge you in any way that would jeopardize your confidentiality. If you choose to greet me, I will be friendly, but will let you lead the conversation.

_____ Initial Here

The following are legal exceptions to your right to confidentiality. I would inform you of any time that I would need to disclose personal information without your permission.

While most of our communication is confidential there are, however, circumstances when disclosure can occur without prior consent. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

1. If I have good reason to believe that you are abusing or neglecting a child, dependent adult, or older adult (age 65 or older), abuse of a disabled person, and abuse of a mental patient or if you give me information about someone else who is doing this, the law requires me to file a report with the appropriate state agency.

2. If you make a serious threat to harm yourself and/or another person, the law requires me to try to protect you and/or that other person. This usually means telling others about the threat and seeking assistance.

3. If you are involved with a court case, (like a child custody case, adoption case, criminal prosecution case, a therapy negligence case or other types of cases) and it is disclosed that you are seeing me, I may then be ordered to show the court my records. Please consult your lawyer about these issues.

4. If you were sent to me by a court or an employer for evaluation and treatment, the court or employer expects a report from me. If this is the 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.

5. If you tell me of the behavior of another named health or mental health care provider that informs me that this person has either a.) engaged in sexual contact with a client including yourself or b.) is impaired in practice due to cognitive, emotional, behavioral, or health problems, then the law requires me to report this to their respective licensing board.

6. If the FBI orders me to release records in keeping with a federal law known as The Patriot Act of 2001, I may be required to provide FBI agents with records of your treatment. This Act prohibits me from informing you that the FBI sought or obtained this information.

II. Record-keeping

I keep written and or electronic records of your treatment, noting your attendance, which interventions were used, and the topics we discussed. You have the right to a copy of your file at any time, unless I believe that this disclosure would cause you psychological harm. If this is the case, I will be happy to provide your records to an appropriate mental health professional of your choice. Because client records are professional documents, they can contain information that is confusing or upsetting when taken out of context. If you wish to review your records, it is best to review them with me so that we can discuss their content together. You have the right to request that I correct any errors in your file. I will always maintain your records in a secure location that cannot be accessed by anyone else.

III. Diagnosis

If a third party such as an insurance company is paying for part of your bill, a diagnosis is often required in order to obtain reimbursement. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from a book titled the ***DSM-V.***

IV. Other Rights

You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You should feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. If you feel you would like to discontinue treatment with me, I encourage you to schedule a meeting to discuss this with me in person. However, this is not required and you are free to leave therapy at any time.

_____ Initial Here

V. Managed Mental Health Care

If your therapy is being paid for in full or in part by a managed care firm, there are usually further limitations to your rights as a client imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to you, to decide the time period within which you must complete your therapy with me, or to require you to use medication if their reviewing professional deems it appropriate. They may also decide that you must see another therapist in their network of providers. Such firms also usually require some sort of detailed reports of your progress in therapy, and on occasion, copies of your case file, on a regular basis. I do not have control over any aspect of these rules. Upon request, I will provide you with the necessary documentation to submit a claim for reimbursement from your insurance company.

VI. Termination

You normally will be the one who decides therapy will end, with a couple of exceptions. If I am not in my judgment able to help you, because of the kind of concerns you have or because my training and skills are not appropriate, I will inform you of this fact and refer you to other providers who may be a better fit. I also have an obligation to refer you to another provider if it becomes apparent over time that my treatment is not benefitting you.

VII. Contacting Me

Clients are seen by appointment. Evening appointments are available. Appointments are made by calling 817-300-4073 or you may contact me through email for initial appointments. I maintain my own appointment calendar, so if I do not answer because I am in session, please leave your name and phone number and I will call you back for scheduling. The very first time I meet with you, we will need to give each other a lot of basic information. During the initial session, we will discuss the type and number of sessions needed. This is variable and dependent on many factors. We will try to schedule sessions for both your and my convenience.

If I need to discontinue our relationship due to illness, disability, or other presently unforeseen circumstances, you agree to my transferring your records to another therapist who will assure their confidentiality, preservation, and appropriate access. By signing this information and consent form, you give your consent to allow another licensed counselor selected by this therapist to take possession of your file and records and provide you with copies upon request, or to deliver them to a counselor of your choice.

I am away from the office at times for vacation or to attend professional meetings. If I am not taking and responding to phone messages during those times, I will tell you well in advance of any anticipated absences, and give you the name and phone number of the therapist who will be covering my practice during my absence. If you are experiencing a crisis and cannot keep yourself safe, please call 911 or if you are able to drive safely, you can go to your nearest emergency room. You can call the National Suicide Prevention Life line at 1-800-273-8255. You may also contact the following for emergency services in **Tarrant County**: Crisis Intervention-Fort Worth at 817-335-3022 or 1-800-866-2465; John Peter Smith Hospital emergency room at 817-369-8699. In **Dallas County**: Dallas Suicide and Crisis Center of North Texas at 214-828-1000; Parkland Psychiatric Clinic at 214-590-5536 or the Parkland Emergency Room at 214-590-8761.

During the course of treatment, I may suggest that you consult with another health care provider regarding additional treatments that could help you. I may suggest that you get involved in a therapy or support group as part of your work with me. If another health care provider is working with you, I will need a release of information from you so that I can communicate freely with that person about your care.

Emergency contact

If there is an emergency during our work together or I become concerned about your personal safety, by signing this form you specifically give me your consent to contact someone close to you (perhaps a relative, spouse, or close friend) and/or medical personnel. If I become concerned about you hurting another person, you specifically give your consent for me to contact your emergency contact, warn the person in danger, and contact necessary medical and law enforcement personnel. Please write down the name and information of your emergency contact person in the blanks provided:

Name_____Relationship_____
Phone Numbers_____
Address _____

_____ Initial Here

My Training

I graduated with a Master of Science in Social Work, from The University of Texas at Arlington in 1989. I have completed therapeutic training in Biofeedback, Eye Movement Desensitization Reprocessing and am a Certified Case Manager (CCM) with the National Board of Certified Case Managers (CCMC).

I am a Licensed Clinical Social Worker, by the Texas State Board of Social Work Examiners. The board contact information is:

Texas State Board of Social Worker Examiners
Texas Department of State Health Services
Mail Code 1982
P.O. Box 149347
Austin , Texas 78714-9347

E-mail: lsw@dshs.state.tx.us
Telephone: (512) 719-3521 or (800) 232-3162
Fax: (512) 834-6677

Responsibilities as a Therapy Client

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 50-60 minutes. The fee for sessions are $110, due at the time of service and payable by cash, check or credit card. Checks are made out to Elder Care Solution Services. Please note there is a $25 fee for returned checks. If we decide to meet for a longer session ahead of time, I will bill you prorated on the hourly fee.
If insurance coverage cannot be verified, or if coverage is denied, then you are responsible in full for these charges.

All fees (co-pays if using insurance) for counseling are due at the time services are rendered, payable by cash, check or credit card. Insufficient-funds checks will be returned upon full payment of the original amount plus $25.00.

If I participate with your insurance, most or all of the charges will be submitted to your insurance company. I may need to furnish medical information to the insurance company to complete the claim process.
If you have medical insurance coverage, for which I am an in-network provider, I will file it and accept the contracted rate. If you have medical insurance, for which I am an out-of-network provider, I will be happy to furnish a statement of service, so that you may file it with your insurance company for any eligible reimbursement.

Some insurance contracts require pre-authorization for mental/behavioral health. I can request pre-authorization for services on your behalf, if I have that information.

I cannot accept barter for therapy. I am unable to run a bill for clients for their therapy. If you are unable to continue therapy because of a change in financial circumstances, please let me know so we can discuss different payment arrangements.

If you are late to your appointment, we will still need to end on time. Fees are not prorated if you are late to your appointment. If you are going to be more than 15 minutes late for your appointment, please call or text me at 817-300-4073. If you do not reach me directly, leave me a message. If you do not do this, I may assume you are not coming and may be unavailable. If this happens, you will still be charged for the session.
If you miss a session without canceling, or if you cancel with less than twenty-four hour notice, you must pay for that session at our next regularly scheduled meeting. The only exception to this rule is if you would endanger yourself by attempting to attend your session (for instance, driving on icy roads without proper tires), or in case of an emergency. Please be aware that missed appointment fees are not covered by insurance, and you will still be held responsible for payment.

I will not voluntarily participate in any litigation or custody dispute in which you, another individual or entity, are parties. It is my policy not to communicate with your attorney and I will generally not provide or sign letters, reports, declarations or affidavits to be used in your legal proceedings unless I am court-ordered to do so. You will be expected to pay for such professional time even if I am compelled to testify by another party. You will also be billed for any time I spend preparing reports, documents, or records that you request, prorated according to my hourly fee.

Complaints

If you're unhappy with what is happening in therapy, I hope you'll talk about it with me so that I can respond to your concerns. I will take such criticism seriously and will address your concerns with care and respect. If you believe that I've been unwilling to listen and respond, or that I have behaved unethically, you can file a complaint with the Texas State Board of Social Work Examiners. To obtain more information on filing a complaint, call 1-800-942-5540.

_____ Initial Here

J. Daniel Bruce, LCSW
Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Patient/Client: _____

Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of J. Daniel Bruce LCSW, Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact J. Daniel Bruce LCSW.

_____ _____
Signature of Patient/Client **Date**

_____ _____
Signature of Parent, Guardian or Personal Representative* **Date**

***If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

□ **Patient/Client Refuses to Acknowledge receipt:**

_____ _____
Signature of Staff Member **Date**

_____ Initial Here

J. Daniel Bruce, LCSW
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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

I are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I are required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment. I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, I must disclose your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. I may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

_____ Initial Here

Deceased Patients. I may disclose PHI regarding deceased patients as mandated by state law or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. I may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. I may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. I may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. I may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. I may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. I may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that I have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at **Elder Care Solution Services 1701 W Northwest HWY, ste 100, Grapevine, Texas 76051**

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if

 _____ Initial Here

the information is contained in separately maintained psychotherapy notes. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information although I are not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with us. I may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. I will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer **J. Daniel Bruce, LCSW, 1701 W Northwest Hwy, ste 100 Grapevine, Texas 76051** or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **I will not retaliate against you for filing a complaint.**

The effective date of this Notice is January 2020.

_____ Initial Here