Centered On You
COUNSELING & CONSULTING
Where You Are The Focus

ADOLESCENT CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____

Your child's name: _____
Last First Middle Initial

Parent or Legal Guardian's Name: _____
Last First Middle Initial

Child's date of birth: _____ **Gender:** _____

Home street address: _____

City: _____ **State:** _____ **Zip:**_____

Parent or Legal Guardian's Name of Employer: _____

Address of Employer: _____

City: _____ **State:** _____ **Zip:**_____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email:** _____

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

_____

Referred by: _____

- May I have your permission to thank this person for the referral?
  Yes **No**
- If referred by another clinician, would you like for us to communicate with one another? **Yes** **No**

Person(s) to notify in case of any emergency: _____
Name Phone

3350 Northlake Parkway, NE Suite B-3
drmoon@centeredonyoucounseling.com
Atlanta, GA 30045
470-525-0033

We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so: (Your Signature):_____

Please briefly describe your child's presenting concern(s):_____
_____
_____

What are your/your child's goals for therapy? _____
_____
_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?_____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses your child has had:_____
_____
_____
_____

Current Medications (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons): _____
_____
_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____
_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons): _____
_____
_____

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Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual
__Transgender __ Asexual __In Question __Other: _____

Racial/Ethnic Identity:
__African/African-American/Black
__American Indian/Alaska Native
__Asian/Asian-American/Asian Pacific Islander
__Bi-Racial/Multi-Racial
__ Latino/Latino-American
__ Middle Eastern/Middle Eastern-American
__White/European-American
__Not listed

FAMILY:

How would you describe your child's relationship with his or her mother?_____
_____
_____

How would you describe your child's relationship with his or her father?_____
_____

_____

Are the child's parents still married or did they divorce?_____ If they divorced, how old was the child when the parents separated or divorced and how do you think this impacted him or her? _____
_____

Please describe your child's relationship with his or her grandparents: _____
_____
_____

Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life: _____
_____
_____

How many sisters does your child have? _____ Ages? _____

How many brothers does your child have? _____ Ages? _____

How would you describe your child's relationships with his or her siblings?_____
_____
_____
_____

SOCIAL SUPPORT, SELF-CARE, & EDUCATION:

POOR EXCELLENT

Child's current level of satisfaction with friends and social support: 1 2 3 4 5 6 7

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How would you describe your child's relationships with his/her peers? _____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

_____

Please briefly describe your child's self-care and coping skills: _____

_____

_____

What are your child's diet, weight, and exercise/activity patterns?_____

_____

_____

Please briefly describe your child's school performance and experience:_____

_____

_____

What are your child's hobbies, talents, and strengths?_____

_____

_____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & *CIRCLE* THE MAIN PROBLEM:

DIFFICULTY WITH:	**NOW**	**PAST**		**DIFFICULTY WITH:**	**NOW**	**PAST**		**DIFFICULTY WITH:**	**NOW**	**PAST**
Anxiety →				Tantrums →				Nausea →		
Depression				Parents Divorced				Stomach Aches		
Mood Changes				Seizures				Fainting		
Anger or Temper				Cries Easily				Dizziness		
Panic				Problems with Friend(s)				Diarrhea		
Fears				Problems in School				Shortness of Breath		
Irritability				Fear of Strangers				Chest Pain		
Concentration				Fighting with Siblings				Lump in the Throat		
Headaches				Issues Re: Divorce				Sweating		

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Loss of Memory					Sexually Acting Out					Heart Problems
Excessive Worry					History of Child Abuse					Muscle Tension
Wetting the Bed					History of Sexual Abuse					Bruises Easily
Trusting Others					Domestic Violence					Allergies
Communicating with Others					Thoughts of Hurting Someone Else					Often Makes Careless Mistakes
Separation Anxiety					Hurting Self					Fidgets Frequently
Alcohol/Drugs					Thoughts of Suicide					Impulsive
Drinks Caffeine					Sleeping Too Much					Waiting His/Her Turn
Frequent Vomiting					Sleeping Too Little					Completing Tasks
Eating Problems					Getting to Sleep					Paying Attention
Severe Weight Gain					Waking Too Early					Easily Distracted by Noises
Severe Weight Loss					Nightmares					Hyperactivity
Head Injury					Sleeping Alone					Chills or Hot Flashes

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems					Physical Abuse				Depression	
Legal Trouble					Sexual Abuse				Anxiety	
Domestic Violence					Hyperactivity				Psychiatric Hospitalization	
Suicide					Learning Disabilities				"Nervous Breakdown"	

Any additional information you would like to include:

_____

_____

_____

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Informed Consent Form for Adolescents

Welcome! You have taken a courageous step in getting support for yourself, your child, teen, and/or family. I am grateful you have selected my practice for you/your family behavioral needs. This document is designed to inform you what to expect from me as your therapist regarding the treatment processes, policies, procedures and other details regarding your treatment. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of the therapeutic experience. Please read carefully through this information and let me know what questions or concerns you may have. Thank you and I look forward to working with you and/or your child. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments or suggesting regarding the course of therapy at any time.

Client Information (***please add additional pages as needed***)

Name: _____ Date of Birth: _____

Parents/Guardians: _____

Address: _____ City/Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer/Occupation/School Info/Grade: _____

Emergency Contact (Name, Relationship, Phone): _____

Referred by:

_____

What is the primary reason you are seeking counseling for your child/adolescent?

_____

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When did you first notice the problem, issue, or symptoms?

What have you already tried to improve the problem or symptoms? What has helped or has not helped?

Has your child or family ever been in counseling before? If yes, please provide approximate dates and provider. What helped or did not help?

Please list current medications, dosage, prescribing physician and office telephone number, and length of time they have been taking this medication.

Please sign to indicate permission to consult with prescribing physician: _____

Date of last physical/well visit checkup: _____

To your knowledge, has your child ever expressed or experienced thoughts or feelings of suicide, self-harm, or harm to others? If yes, please provide approximate time frame(s) and details.

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Please describe any significant medical history (including chronic conditions, hospitalizations, surgeries, premature birth, etc.)

Has your child achieved developmental milestones (e.g., walking, talking, toilet training) within normal limits? Have you had any developmental concerns as your child has grown?

Please describe any significant transitions, losses, or traumatic events your child has experienced (examples: moving, changing schools, divorce/separation, death, illness of a close family member or friend)

Please list the names, ages, and relationship of all individuals currently living in your home

What goals or changes would you like to see accomplished by your child and/or family through counseling?

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Please list anything else you would like me to know before we begin our work together. _____

Psychological Services

Psychotherapy refers to a variety of mental health interventions provided by a licensed mental health professional to a client. It works, in part, because of clearly defined rights and responsibilities held by each person, which helps create an atmosphere of safety and support needed to take steps toward change. Psychotherapy has been shown to have many benefits including the reduction of emotional distress, improved relationships, and solutions to specific problems. Risks of psychotherapy may include temporary unpleasant emotions that can result from discussing and reflecting on unpleasant aspects of your life. There are no guarantees about what will happen. To be most successful, you will have to work on things we discuss outside of sessions.
Initials _____

Therapist Background Information, Theoretical View & Client Participation

I believe we have the necessary tools within to create peace and fulfillment in our lives. However, sometimes we may need guidance in constructing new pathways of wholeness and correcting unhealthy patterns of thinking and behaving. My theoretical view incorporates Cognitive Behavior, Solution-Focused Therapy, Narrative Therapy, along with integrating complementary methodologies and techniques specific to each client's needs. My experience includes the following: Licensed Professional Counselor, National Certified Counselor, Approved Clinical Supervisor and a PhD from the University of Georgia in Counseling. I have been in the counseling field for over 13 years and trained to provide individual counseling to adults and adolescents with a range of psychological issues.
Initials _____

Confidentiality

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in my locked office. Additionally, I will always keep everything you say to me completely confidential, with the following exceptions: (1) you direct me to tell someone else and you sign a "Release of Information" form; (2) I determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information.
Initials _____

Confidentiality and Minors

Legally, the parent(s) or legal guardian(s) of child clients (under the age of 18) have the right of confidentiality. To establish and preserve the essential relationship and setting for a child's therapy, I honor what the child or teen says or does in our sessions as confidential while providing parents/guardians periodic summaries of treatment goals, plans, recommendations, and progress. I will explain this process to your child and ask that you reinforce it also. The exceptions are (1) your child/adolescent directs me to tell someone else and you sign a "Release of Information" form; (2) I determine

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that your child is a danger to herself/himself or to others; (3) your child reports information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information.
Initials _____

Divorce and Custody Cases

I am not a custody evaluator and cannot make any recommendations on custody. I can refer you to a list of licensed psychologists if needed. Due to the sensitive nature of divorce and all potential issues that may arise in such cases, I have very specific policies to which you must agree to before we enter into a counseling relationship.

1) If I am seeing a child whose parents are in the process of divorce or already divorced, I require a copy of the standing court order demonstrating the custodial rights of each parent and/or the parenting agreement signed by both parents and judge.
2) Identical summaries of the child's therapy progress, treatment plan, and parent recommendations are available to both parents who share in the legal custody of the child client and I will offer and encourage opportunities for both parents to participate in parent consultations along the way. Family sessions may be recommended.
3) I ask all clients to waive right to subpoena me to court. This policy is set so that I can preserve the efficacy and integrity of the therapeutic progress and relationship with you and/or your child(ren). My appearance in court often damages the client-therapist relationship and it is my ethical duty to make every reasonable effort to promote the welfare, autonomy, and best interests of my clients. By signing this agreement, you are waiving the right to have me subpoenaed and agreeing not to have me or my records subpoenaed.
4) In the case I am subpoenaed to appear in court even with this waiver – whether I testify or not – I charge my full standard fee for court related work of $400 per hour for my professional time. Any time dedicated to any court mandated appearance including preparing documents for discussions with attorneys and/or guardian ad litem in connection to the court appearance and any time spent waiting at the court house in addition to time on the stand as well as travel time will be billed at $ 250/hour.

I understand these policies and hereby waive all rights to subpoena Natasha Moon, PhD, LPC, NCC, her clinical record, or any current or future legal proceedings.

_____	_____	_____
Printed Name	Signature	Date

Initial Session

The initial meeting will be 60 minutes in length. This session can be structured in many ways. Consultation with the parents, guardians or adults that interact most with the child or young adult is very important. The initial session may involve meeting only with these adults; however, if time allows I will hold a split session where I meet with the adult(s) and then the child or young adult. The next few sessions will involve a comprehensive evaluation of client's needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable with me working with your child. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.
Initials _____

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Appointments and Scheduling

A minimum of 24 hours is required to cancel an appointment. If a client does not arrive for a scheduled appointment or cancels with less than 24-hour notice, full session payment is due. If there is a true, unavoidable emergency or if serious or contagious illness, please call me as soon as possible and I will work with you to reschedule within the same week when possible. If sudden onset, please call me as soon as possible and request waiver of 24-hour policy. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time to ensure other clients' appointments are not impacted.

Initials _____

Session Length and Fees

Initial intake session $125.00, 60 minutes

Individual therapy, $115.00, 45/50 minutes

In addition to weekly appointments, it is my practice to charge $175 an hour for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. Method of payment include: cash and credit/debit. There is a $35 fee for any service not processed.

Initials _____

After Hours Support and Emergencies

Centered on You Counseling & Consulting is by appointment only and not an emergency services facility. I do not provide emergency services. You may call me during business hours and leave me a confidential voicemail including your telephone number (even if you know I have it). I will call you back when I have finished all sessions or between sessions when possible. I do not answer calls when I am with clients. I strive to return all calls within 24 hours, though occasionally, it may take up to 48 hours depending on schedule and day of week. When I will be out of the office for an extended period, I update my voicemail and email messages to reflect when I will return and provide all current clients with advance notice. If you have a mental health emergency, call 911 or go to the hospital of your choice FIRST. Only contact me after emergency services have been obtained for your safety. You can also reach me during business hours or on an emergency basis after hours at 470-525-0033. Some additional emergency services facilities include: (not to be substituted for 911 for life threatening emergencies):

Ridgeview Institute 770-434-4567
Summit 678-422-5858

Peachford Hospital 770-455-3200
Go to the nearest emergency room

Initials _____

Release of Information and Records

Clients or their legal guardians often request that I obtain or provide information to other healthcare or mental health professionals, schools, insurance companies, and other relevant parties. For clients over 18, a signed authorization form must be filled out by the client to allow me to speak to anyone regarding their care, even parents. For children and teens, parents or legal guardians must fill out an authorization form before I can even acknowledge knowing the client.

Pursuant to HIPAA, I keep information about clients in a collection of professional records, known as your clinical record. You may receive a copy of your clinical record if requested in writing. Because these are clinical records, they are easily misinterpreted by untrained readers. For this reason, I recommend reviewing them together within a scheduled session or have them forwarded to another mental health professional so you can discuss the contents. There is an administrative fee of $35 for copying and mailing the record for release.

Initials _____

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Quality of Service

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you/your child to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, you have the right to ask questions about any aspects of therapy and about my specific training and experience. If you feel I have behaved in an unprofessional or unethical manner, please advise me so that the problem can be clarified and resolved. If you feel that this does not resolve the issue, you may contact the following:

Georgia State Department of Licensing
Composite Board of PC, SW & MFT
237 Coliseum Drive
Macon, Georgia 31217
478 207 1670

Initials _____

Our Agreement to Enter into a Therapeutic Relationship

I am sincerely looking forward to working with you and your child. If you have any questions about any part of this document, please ask. Please print, date, and sign your name below indicating that you have read and understand the contents of this "Information, Authorization and Consent to Treatment" form as well as the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices" provided to you separately. Your signature also indicates that you agree to the policies of your relationship with me, and you are authorizing me to begin treatment

_____

Client (or parent/legal guardian of child client) Printed Name

_____ _____

Client (or parent/legal guardian of child client) Signature Date

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Insurance Verification Worksheet

Client Name: _____ **Parent Name:** (if child is client) _____
DOB: _____

Insurance Information: *Please phone your Insurance Company and fill out this form the best you can.*
This is very helpful information if you are unfamiliar with your coverage.

Name of Insurance: _____ **Phone: (____)** _____
Insured's Name: _____
ID #: _____ **Plan/Grp #:** _____

When you call, be sure to write down the name of the person that you talk to for later reference.
HMO Contact Person: _____ **Date & Time of call:** _____
Say, "I'm calling to clarify my benefits and coverage for out-patient mental health." (They will ask for your member ID #) *Ask enough questions to complete all of the information. Incomplete information will require another phone call.*
Is my therapist, Natasha Moon, LPC, or Centered on You Counseling & Consulting, on the Participating Provider List?
If not on their panel, then ask these questions:
"Does my policy allow me to choose my own therapist?" Yes No
"Can I go outside of the panel or the provider list?" Yes No (If so, "Is my coverage different? How?") _____
Then ask: "What is my:
Copay: _____% **or** $ _____**/session. Whichever is less.**
Effective Date of Policy: _____

Deductible? No Yes **Amount of Deductible** $ _____ **family or individual?**
_____
Has any Deductible been met for this year? No Yes **If yes, how much?**
_____
Is Pre-authorization needed? No Yes **Any benefits used to date?** Yes No
 # Visits allowed per calendar year _____

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client's Name: _____ Birth Date: _____

I, _____, authorize, Independent Practitioner, ___Dr. Natasha Moon, LPC_____
Responsible Party Name — Therapist's Name

at Centered on You Counseling & Consulting, LLC, to **[release] [request] [share]** (circle all that apply) confidential medical record information

[to] [from] [with] (circle all that apply), _____ _____ .
Therapist/School Official — Phone

Information shall consist of: Duplicate records and/or verbal consultation concerning treatment and/or education.

Specifically:
☐ All Clinical Records ☐ Educational Evaluation
☐ Mental Health Info ☐
☐ Other: _____

The information is needed for adopting a more comprehensive and integrated approach to my health care and maintaining a continuity of care for this purpose only unless other wise permitted or required by law.

This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired. If not revoked, it shall terminate the last day of the clinical treatment.

A photocopy, facsimile or duplicate copy of this authorization shall be as valid as the original.

The person signing this consent has a right to receive a copy of it. My initials, _____ indicate that I have received a copy of this authorization to release medical records.

I have read and understand the nature of this release. I understand that I may revoke it at any time. I release the therapist and the above-named organization from any liability that may arise from this action whether foreseen at present.

_____ _____
Signature of Client — Date

_____ _____ _____
Signature of Legal Representative (If client is a minor or incapacitated) — Relationship to Client — Date

_____ _____
Witness — Date

I do not give my mental health provider permission to contact my primary care physician, therapist or other type of provider.

_____ _____
Signature of Client — Date

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Client's Name: _____ Date of Birth: _____

Parent's Name (if applicable): _____

Health Insurance Portability and Accountability Act (HIPAA) Rights:

I acknowledge Centered on You Counseling & Consulting, LLC adheres to the federal mandates of the HIPAA laws. My signature below acknowledges receipt of this notice. I can receive the full disclose in print, email, or by fax, upon request.

_____ _____
Patient or Authorized Person's Signature Date

AUTHORIZATION FOR BILLING

I authorize the Release of any medical or other information necessary to process my health care claims including a clinician diagnosis, understanding that all information shared is protected health information and will fall in compliance to HIPAA laws.

_____ _____
Patient or Authorized Person's Signature Date

I authorize payment of medical benefits to Natasha Moon, LPC, Centered on You Counseling and Consulting, LLC for healthcare services rendered.

_____ _____
Patient or Authorized Person's Signature Date

Policy Holder's Name:
Address:
Date of Birth:
Cardholder Name if different
Credit Card Type: Visa Mastercard Discover
Credit Card Number:
Expiration Date: **Card ID Number (last 3 digits on back of card)**

Please note: If you miss an appointment or do not cancel within 24 hours in advance; you will be assessed a missed appointment fee.

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HIPAA Notice

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I 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 I provide, coordinate or manage your health care and other services related to your health care. An example would be when I consult with another health care provider, such as your family physician or another psychologist.

Payment is when I obtain reimbursement for your healthcare. Examples are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations are activities that relate to the performance and operation of my practice. Examples 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 my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or 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 I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information.

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

III. Uses and Disclosures with Neither Consent nor Authorization

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

Child Abuse – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.

Adult and Domestic Abuse – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.

Health Oversight Activities – If I am the subject of an inquiry by the Georgia Board of Psychological Examiners, I may be required to disclose protected health information regarding you in proceedings before the Board.

Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent 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 I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

Worker's Compensation – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Counselor'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. However, I am 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. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial 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. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

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

Counselor's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will provide you with a revised notice at your next session.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at 470-525-0033.

If you believe that your privacy rights have been violated and wish to file a complaint with me/my office, you may send your written complaint to me at 3350 Northlake Pkwy, NE; Suite B-3; Atlanta, GA 30345.

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

I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect June 2017. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by the time of your next session.