

## Understanding Neuropsychological Evaluation and Informed Consent

You have taken the first step to feel more successful and empowered in your life by choosing to participate in a Neuropsychological Evaluation. Thank you for selecting Therapy Changes and Coastal Neuro Group as the place for your assessment. This document was created to help you understand the policies and procedures for an evaluation and prepare you for the steps ahead. Please thoroughly review this document, as it contains information that is very important for you to know.

### **Understanding Neuropsychological Evaluation**

Neuropsychological Evaluation is a process of testing that uses a combination of techniques to help arrive at some hypotheses about a person and their behavior, personality, and capabilities. It is important to know that Neuropsychological Evaluation is not the same as Psychotherapy. Unlike Psychotherapy, Evaluation includes the use of psychological tests that are administered by a Licensed Psychologist. These tests are standardized, objective, and quantitative.

#### *Nature of Assessment*

Neuropsychological and psychological evaluation includes a comprehensive evaluation of a person's intellectual, academic, and/or emotional functioning. Results from evaluations can be used to give opinions and make recommendations concerning diagnosis, treatment, rehabilitation, job or school functioning, ability to drive, ability to live independently, and/or the need for further evaluations. When appropriate, this information can be shared with the individual being evaluated, his or her family members, teachers, or health care providers. Information from your evaluation is not intended for legal purposes.

The Neuropsychological Evaluation process takes place in four primary stages:

1. **Intake Interview**

The intake interview is conducted between the client and the therapist. The purpose of this interview is to obtain background information, discuss your concerns, and identify the objectives for the evaluation. This process can take 60 – 90 minutes.

2. **Testing**

Psychological testing may take place over the course of one or more sessions lasting 1-2 hours per session. The total testing time usually ranges between 4 – 8 hours, depending on the individual needs of the client, which is determined during the intake interview.

3. **Scoring, Interpretation, and Report Writing**

Your therapist will score and interpret the results from testing. In addition, your therapist may prepare a report depending on your needs. The amount of time dedicated to this process typically ranges from 3 – 9 hours.

4. **Client/Parent Feedback Meeting**

Your therapist will invite you to a feedback meeting to provide interpretation about the testing results, review diagnostic impressions, and discuss treatment recommendations. This meeting will take place about 2 – 3 weeks after the completion of the testing process and will last approximately 60 – 90 minutes.

In addition to the stages of the Neuropsychological Evaluation described above, other services are sometimes necessary. For example, your therapist may find it helpful to speak with other professionals involved in your care, or your child's care. Such professionals can include teachers, physicians, counselors, or other therapists. For some children, a school observation may be recommended to provide a better idea of how your child is functioning in his or her educational setting. In some cases, your evaluation may include an interview with your closest family member(s) and/or significant other(s). If consultation with outside parties is necessary, you will be asked to sign an Authorization to Release Information form prior to any communication.

### **Child and Adolescent Neuropsychological Evaluations**

Depending on the child's age and nature of the concern, the initial intake interview may include a private conversation between the child and therapist. At this session, consent for treatment will be required from parent(s)/legal guardian(s). Neuropsychological Evaluations will not begin without applicable consents. If any question exists regarding the authority of the representative to give consent for therapy, the therapist will request supporting legal documentation, such as a custody order, prior to the commencement of services.

#### *Privilege*

In order for an accurate assessment to be conducted, a safe and private environment must be created for the child or adolescent. Thus, the dialogue and the content of the sessions between the child and therapist will remain private. Limitations include any instances of safety concerns which will be determined by the therapist. If such situations arise, both the therapist and the child will discuss these issues with the child's parent or legal guardian.

#### *Pickup and drop-off policies*

The Therapy Changes office is not able to accommodate children outside of a scheduled appointment time. Unattended children in the waiting room can represent a safety issue, as no supervision is available during this time. Parents and guardians are asked to arrive *no earlier than five minutes* before their child's appointment. Parents and guardians are encouraged to wait for their child in the office for the first one or two sessions in case the therapist has a question or if your child would benefit from your presence. After the first one or two sessions most parents/guardians feel comfortable leaving the office. In such cases, we ask for a *timely pickup* and that during this time parents/guardians are available via cell phone.

### **Limits of Neuropsychological Evaluation**

There are many potential benefits to Neuropsychological Evaluations that include diagnostic clarification, individualized treatment recommendations, insight into the nature of your strengths and areas of impact, as well as providing a written report to assist in facilitating services in the community or at school when necessary. Although most individuals have a positive experience during the assessment process, it is always possible to experience discomfort such as frustration, anxiety, or embarrassment. In addition, it is important to know that the results of the Neuropsychological Evaluation may not answer all of your questions about your situation, or your child's situation. Thus, other referrals may be made to other service providers.

Testing results may prove invalid due to a variety of factors, including changes in health status, some types of on-going medication or medical treatment, lack of motivation, or attempts to manipulate the testing results. Please inform your therapist of any current health issues, current medications, or other factors that may influence test validity.

## **The Therapeutic Relationship**

The relationship between you and your therapist is very special and unique. You will be sharing information with your therapist that may be sensitive and intimate. It is not your therapist's job to make judgments or give advice. Rather, the therapist's role is to understand your concerns and take this into consideration when formulating treatment recommendations. It is important to know that Neuropsychological Evaluation is not Psychotherapy. Completion of testing does not imply an on-going psychotherapeutic relationship with your therapist, unless such a relationship has been specifically and mutually agreed upon.

You can always count on your therapist for professional help. With time, you may come to feel close to your therapist and may wish to spend time with him or her in a social environment. In order to protect your confidentiality and maintain professionalism, therapists and clients do not socialize together. One of the biggest violations of the therapist's role is if a therapist has a romantic or sexual relationship with his or her client. While talking about sexual thoughts or feelings is a part of therapy for many people, sexual relations between a therapist and client is never appropriate.

In therapy, the focus is always on you. This is a luxury that everyday life doesn't often give us. At first this luxury may seem a little awkward; you may not be used to talking about yourself to someone who doesn't tell you much about themselves in return. After a while this uneasiness usually goes away and you may find yourself enjoying the time that is devoted solely to you.

You are encouraged to be honest with your therapist about your feelings, not only about others, but also about your therapist. This is the best and safest way to cultivate a stronger sense of self and an effective working relationship.

## **Limits of confidentiality**

In accordance with professional ethics and California law, the information you reveal in your assessment sessions is confidential, and will not be shared with anyone without your written permission, except as required by law.

Some of the circumstances where disclosure is required by California law are when there is a reasonable suspicion of child, dependent or elder abuse or neglect. This includes instances when material has been accessed, streamed, or downloaded where a child is engaged in an obscene sexual act. If you are a danger to yourself, to others, or to property of another person, or if you are gravely disabled, your therapist is mandated to make a report to the appropriate authorities. Your therapist is also obligated to disclose information if a close family member communicates to the therapist that you are a danger to others.

Disclosure may also be required during a legal proceeding by or against you. For example, if your mental status is questioned during litigation, therapy records and/or testimony by your therapist may be required by a Court Order. Your therapist will use his or her clinical judgment when revealing such information, and will do his or her best to minimize disclosure unless absolutely necessary. Please review the *Notice of Privacy Practices* for additional information about confidentiality, electronic transmissions and requests for records.

### *Health insurance and confidentiality of records*

Disclosure of confidential information may be required by your health insurance carrier in order to process claims. In such cases, your therapist will communicate only the minimum necessary information to the carrier. Therapy Changes has no control or knowledge over what insurance companies do with the information that is submitted or who has access to your information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance, or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computer and is likely to be reported to the national Medical Data Bank. Accessibility to companies' computer or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to unauthorized access. Medical data has been also reported to be legally accessed by enforcement and other agencies, which also may put you in a vulnerable position.

### *Electronic communications*

For your convenience, statements, superbill receipts, appointment reminders, and private messages from your therapist may be sent to you through our practice software, Therapy Appointment. Such information can be accessed by a password that is only known to you. If you forget your password and need to access your private health information, please contact our office. Communications transmitted electronically through Therapy Appointment are compliant with the Health Information and Accountability Act (HIPAA) and are thus secure.

You may also receive electronic communications from your therapist such as E-mail that is **not secure**. E-mail can be relatively easily accessed by unauthorized people and can compromise your privacy and confidentiality. A non-encrypted e-mail, such as your therapist's email, is even more vulnerable to unauthorized access. Although your therapist's emails are not encrypted, privacy measures are taken such as firewalls on your therapist's computer as well as virus protection and the use of a password. Please do **not** use SMS (mobile phone text messaging) to contact your therapist. Engaging in this way can compromise your confidentiality.

Phone contacts between sessions can be helpful for discussing particular events or situations that are causing you distress. If phone contact becomes routine and/or a phone conversation becomes lengthy, you may be charged. E-mail and phone communications are helpful tools for asking general questions of your therapist, confirming appointments, and conveying relevant information and updates. However, e-mail and out-of-session phone contact should not be used as a substitute for a session in the office. Your therapist cannot conduct assessments over the phone or via email. In such cases that lengthy or disclosing emails are received, your therapist will invite you to a conversation in the office.

Please notify your therapist if you decide to avoid or limit, in any way, the use of secure messaging or E-mail. Otherwise, your therapist may communicate with you via secure messaging or E-mail when necessary or appropriate. If you communicate confidential or highly private information via E-mail, your therapist will assume that you have made an informed decision and will honor your desire to communicate via e-mail. Please do not use E-mail for emergencies. Please, note that all electronic communications are part of your clinical record.

### **Social Media Policy**

At Therapy Changes we make your privacy our priority. Your therapist's policies regarding conduct on social media platforms are to ensure a professional relationship and protect your privacy. The nature of the confidential relationship between you and your therapist is known to contribute to the effectiveness of therapy.

### *Friending and following*

Your therapist will **not** accept friend or contact requests from current or former clients on any social networking site such as Facebook or LinkedIn. Therapy Changes maintains accounts on select social media platforms. These accounts are not managed by any individual therapist. Rather, these accounts are associated with the practice and allow public access to blog posts and relevant news and community resources. Clients are encouraged to view the Therapy Changes Facebook, Twitter, or LinkedIn page and read or share articles posted there. The Therapy Changes Twitter account only follows other mental health professionals as well as state and local organizations. There is no expectation for clients to follow any social media account. You should be able to subscribe to social media accounts via RSS without becoming a fan and without creating a visible, public link to this page.

Please do not attempt to contact your therapist or the Therapy Changes office via social networking sites. This could compromise your confidentiality and you will not receive a response as these sites are not monitored regularly.

### *Online reviews*

We understand that there are more choices than ever when it comes to choosing the right therapist. With the Internet impacting virtually all aspects of our lives, it has been increasingly more common for consumers to find and vet businesses online. In the case of psychological assessments, online reviews such as Yelp.com pose a unique challenge for both the therapist and client. Therapy Changes or your individual therapist may be listed on one or more of these sites. If you should find a listing, please know that this is not a request for a testimonial, rating or endorsement from you. It is unethical for your therapist to solicit a testimonial from a current or former client. If you post an online review based on your experience during an evaluation, you are publicly acknowledging a therapist-client relationship and have thus waived your right to privacy. You should be aware of any potential negative impact that could occur on the basis of this disclosure such as the possibility of this exchange becoming a part of your legal medical record. Your therapist cannot respond to any review on a business review site for confidentiality reasons. Instead, we invite you to share your comments – either positive or negative directly with us. Your therapist is always willing to discuss your reactions and work with you to make your experience in therapy a positive one.

### *Social networking & internet searches*

It is not part of your therapist's regular practice to search for clients via Google or other social media platforms. Extremely rare exceptions may be made during times of crisis. If your therapist ever resorts to such means, he or she will fully document and discuss this with you at your next appointment.

### **Emergencies**

The Therapy Changes office does **not** offer emergency services. Your therapist can be reached during his or her personal business hours by calling Therapy Changes at 619-275-2286 and entering your therapist's extension. Please note that your therapist may not be immediately available to handle emergency situations. If you are in need of emergency assistance, call '911' or the San Diego Crisis Line at 1-888-724-7240. If you or someone you know is in danger of attempting suicide, call the National Suicide Prevention Lifeline at 1-800-273-8255. Unless otherwise specified, phone messages will be returned by your therapist within 24 hours.



### *Missed appointments and late cancellations*

Your appointment is reserved exclusively for you. If you missed your appointment or cancel at the last minute, we will be unable to care for another client. Thus, **missed appointments, or those cancelled within 48 hours of scheduled appointment time are subject to a \$180 missed appointment fee.** The credit card on file will be charged in the case of missed appointments or late cancellations. A receipt for each payment is available upon request.

Client Initials: \_\_\_\_\_ Therapist Initials: \_\_\_\_\_

### *Superbills*

Superbills are specialized statements that include the type of service provided, the date services were rendered, and a formal diagnosis. These statements are prepared upon request and provided at the conclusion of services. You have the option to submit Superbill statements to your insurance company for possible partial reimbursement.

### **Other Office Policies**

#### *Scheduling appointments*

Appointments will be made using the convenient and easy to use practice software, Therapy Appointment. This system allows you access your therapist's personal calendar as well as receive reminder emails. You are encouraged to schedule your appointments online for ease of convenience and to reserve your preferred appointment day and time. Refer to the '*electronic communications*' section of this document for privacy information.

#### *Animals in the office*

In order to ensure the comfort and safety of our clients and staff, we ask that you refrain from bringing any animals or pets into Therapy Changes common and office areas. This will allow us to provide a more comfortable space for clients. Thank you for your understanding.

Therapy Changes adheres to the requirements set forth by the U.S. Department of Justice and the Americans with Disabilities Act (ADA) for the allowance of Certified Service Animals. For those clients who currently have a Certified Service Animal, we ask that you speak with your therapist individually to discuss your treatment goals and determine whether it would be clinically appropriate and beneficial to bring your Service Animal to your session.

#### *Arriving on time for your appointment*

Please make effort to arrive to your appointment on time. If you arrive early you are welcome to wait in our comfortable waiting area and relax before your meeting. You will benefit the most from participating in a full session. We understand that some things are out of your control such as traffic. In the case that you know you will be late for your appointment, please call ahead. If you are more than twenty minutes late your therapist may decide that it is not in your best interest to hold the session. In such cases, you may incur a missed session fee. If arriving late to your appointments becomes a pattern and it interferes with your assessment, you and your therapist can discuss alternative solutions such as meeting at another time or location, or receiving care from another therapist.

Client Initials: \_\_\_\_\_ Therapist Initials: \_\_\_\_\_

*Professional will*

In the event that your therapist is suddenly unable to continue to provide professional services or maintain client records due to incapacitation or death, he or she has designated a trusted professional colleague to be his or her professional executor. Your therapist's professional executor will be given access to your file and may contact you directly if such a circumstance should occur. Your therapist's professional executor may offer to meet with you to help cope with the transition, or assist you in accessing care with another qualified mental health professional.

Please complete and sign below to indicate that you understand and agree to the above, and consent to treatment. You are encouraged to keep a copy of this form and refer to it from time to time during your therapy.

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**Informed Consent and Agreement for Neuropsychological Evaluation**

I, \_\_\_\_\_ [your name] agree to the following services:

- Psychological testing, assessment, or evaluation including scoring and interpretation
- Consultation with school personnel
- School observation
- Consultation with attorneys
- Deposition (written testimony given to a court, but not made in open court)
- Testimony in court
- Other (describe): \_\_\_\_\_

The type(s) of feedback you or your child would like to receive:

- A comprehensive written report that provides findings for each measure, an integrative summary, and recommendations for treatment and/or other interventions
- A brief, written summary report (approximately one page) that provides an overview of findings and recommendations
- In-person, verbal feedback
- Other (describe): \_\_\_\_\_

This agreement concerns  myself or  \_\_\_\_\_

I understand that this evaluation is to be done for the purpose(s) of:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_



I understand that the fee for these services will be approximately \$ \_\_\_\_\_. I also understand that at the conclusion of the evaluation, the credit card on file will be charged the balance due on my account.

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By signing below, I acknowledge that I consent to Neuropsychological Evaluation by Therapy Changes, and that I have been informed of the policies regarding evaluations. I fully understand my rights and obligations as a client of Therapy Changes and freely agree to this agreement for Neuropsychological Evaluation.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client

*If client is a minor, all legal guardians must sign below:*

\_\_\_\_\_  
Signature of Client's Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Legal Guardian

\_\_\_\_\_  
Signature of Client's Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Legal Guardian

## Acknowledgement of Receipt: Notice of Privacy Practices

I have read and understand Therapy Changes Notice of Privacy Practices outlined below.

Signature of Client	Date	Printed Name of Client
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*If client is a minor:*

Signature of Client's Legal Guardian	Date	Printed Name of Legal Guardian
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***You may refuse to sign this acknowledgement***

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### Required HIPAA Notice of Privacy Practices

**I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IT WILL GENERALLY PROTECT YOUR PRIVACY TO A MUCH GREATER DEGREE THAN REQUIRED BY THE LANGUAGE OF THE DOCUMENT.**

**II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)**

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you which I have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of the health care. I must provide you with this Notice about my privacy practices and such Notice must explain how, when, and why I will “use” and “disclose” your PHI. A “use” of PHI occurs when I share, examine, give, or otherwise divulge to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. I am legally required to follow the privacy practices described in this Notice; however, I reserve the right to change the terms of the Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office.

**III. HOW I MAY USE AND DISCLOSE YOUR PHI**

I will use and disclose your PHI for many different reasons. I will need your prior written authorization for some of these uses or disclosures; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

**A. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations Do Not Require Your Prior Written Consent.** I can use and disclose your PHI without your consent for the following reasons:

- i. **For Treatment.** I can use your PHI within my practice to provide you with mental health treatment including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care

*Therapy Changes*

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providers who provide you with health care services or are involved in your case. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

- ii. **To Obtain Payment for Treatment.** I can use your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
- iii. **For Health Care Operations.** I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who have provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.
- iv. **For Patient Incapacitation or Emergency.** I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent is not required if you need emergency treatment as long as I try to get your consent after treatment is rendered; or, if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

**B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization.** I can use and disclose your PHI without your consent or authorization for the following reasons:

- i. **When federal, state, or local laws require disclosure.** For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to governmental agencies and law enforcement personnel about victims of abuse or neglect.
- ii. **When judicial or administrative proceedings require disclosure.** For example, I may have to use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or claim for workers' compensation benefits. I may also have to use or disclose your PHI in response to a subpoena.
- iii. **When law enforcement requires disclosure.** For example, I may have to use or disclose your PHI in response to a search warrant.
- iv. **When public health activities require disclosure.** For example, I may have to use or disclose your PHI to report to a governmental official an adverse reaction that you may have to a medication.
- v. **When health oversight activities require disclosure.** For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.



- vi. **To avert a serious threat to health or safety.** For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. Any such disclosures will only be made to someone able to prevent the threatening harm from occurring.
- vii. **For specialized government functions.** For example, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations, if you are in the military.
- viii. **To remind you about appointments and to inform you of health-related benefits or services.** For example, I may have to use or disclose your PHI to remind you about your appointments or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

- C. **Certain Uses and Disclosures Require You to Have the Opportunity to Object.** Disclosures to family, friends, or others: I may provide your PHI to a family member, friend, or other person that you indicate that is involved in your care or the payment for your health care unless you object in whole or in part. The opportunity to consent may be obtained retroactively in an emergency situation.
- D. **Other Uses and Disclosures Require Your Prior Written Authorization.** In any situation not described in sections III A, B, and C, above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.

#### IV. **WHAT RIGHTS YOU HAVE REGARDING YOUR PHI**

You have the following rights with respect to your PHI:

- A. **The Right to Request Restrictions on My Uses and Disclosures.** You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members, friends, or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests but am not legally required to accept them. If I do accept your requests I will put them in writing and will abide by them except in emergency situations. Be advised that you may not limit the uses and disclosures that I am legally required to make.
- B. **The Right to Choose How I Send PHI to You.** You have the right to request that I send confidential information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.
- C. **The Right to Inspect and Receive a Copy of Your PHI.** In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect

and receive a copy of such information in writing. If I do not have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

- D. The Right to Receive a List of the Disclosures I Have Made.** You have the right to receive an Accounting of Disclosure listing the instances in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use; disclosures permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; and, disclosures made before April 14, 2003. I will respond to your request for an Accounting of Disclosure within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year I may charge you a reasonable, cost-based fee for each additional request.
- E. The Right to Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide, in writing, the request and your reason for the request. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request to amend your PHI, I will make the changes, tell you that I have done it, and tell others that need to know about the change to your PHI.
- F. The Right to Receive a Paper Copy of This Notice.** You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

**V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**

If you think that I may have violated your privacy rights, or you disagree with a decision I have made about access to your PHI, you may file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S. W., Washington D. C. 20201. I will not take retaliatory action against you if you file a complaint about my privacy practices.

**VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES:** Rochelle Perper, Ph.D., 2221 Camino del Rio South, Suite 200, San Diego, CA 92108, (619) 275-2286.

**VII. EFFECTIVE DATE OF THIS NOTICE**

This notice went into effect on September 1, 2018.