Therapy Changes
Focused guidance when you need it most

2221 Camino del Rio South, Suite 200, San Diego, CA 92108
Phone 619-275-2286 | Fax 619-955-5696
www.TherapyChanges.com

New Client Packet for Group Therapy – Solution-focused Sobriety Group

Welcome to Therapy Changes. Please complete the following. All information is kept ***confidential***.

Client name: ______________________________________ ________________
Date of Birth

Person completing this form: ___________________________ ________________
Relation to Client

Preferred method of contact: ☐ Phone ☐ Email If phone, ok to leave a message? ☐ Yes ☐ No

Ethnicity: ☐ African-American ☐ American/Alaskan Indian ☐ Anglo ☐ Asian
☐ Latino/a ☐ Pacific Islander ☐ Other: ________________

Religion: ☐ Buddhist ☐ Catholic ☐ Christian ☐ Hindu ☐ Jewish
☐ Islamic ☐ Protestant ☐ None ☐ Other: ________________

Affectional/Sexual Orientation: ____

Gender Identification: ____

Relationship Status: ☐ Single, not dating ☐ Single, dating ☐ Committed Relationship
☐ Married ☐ Divorced ☐ Other: ________________

Emergency Contact:

____ ________________
Name Relation to Client Phone Number

Please list any chronic or major medical concerns: ____________________________________
____

Please list any history or current substance use (drug/alcohol):

Substance Frequency Substance Frequency
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Do you experience thoughts of harming yourself or others? ☐ Yes ☐ No

How did you hear about Therapy Changes?_______________________________________

May we have permission to thank him or her? ☐ Yes ☐ No ☐ NA

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Understanding Group Therapy and Consent to Treatment

The success of group therapy depends upon a high degree of trust between you, your group facilitator, and fellow group members. This document has been prepared to fully inform you about what to expect from group therapy and from your group facilitator.

About Us

Therapy Changes was established in 2011 by Rochelle Perper, Ph.D. and is comprised of a group of independent practitioners. All therapists at Therapy Changes are independent contractors and licensed Psychologists in the state of California. The team at Therapy Changes is committed to providing *focused guidance when you need it most* – when going it alone can feel overwhelming and hopeless. Our mission is to provide professional care, comfort and support, so you can feel empowered to make positive change in your life.

Understanding Group Therapy

The Solution-focused Sobriety Group is designed to allow you to focus on the positives of living a sober life. Through participation in this group you will have opportunities to focus on yourself and other group members' strengths, resources, and successful coping skills. You will have the chance to look at the past, present and future in a positive light. Your group facilitator will help you understand what was different before the problem started, the positives about your current situation, and how things can change for the better in the future.

This group focuses on the positive to empower you to work toward your goals, such as sobriety from all drugs and alcohol. The solution-focused Sobriety Group is not a class with specific tasks or learning objectives. Rather, you will define your personal goals, and choose the path that is right for you. Everyone is different, so what works for one person in recovery may not work for another. This group supports diversity, as members often come from different stages of life, backgrounds, and stages of recovery.

Objectives of group therapy include, but are not limited to:

- Better understand your strengths, resources, and coping skills
- Assist others in understanding the positives within each one of us
- Share your thoughts and feelings about your life and goals
- Listen and give support to other group members
- Feel a sense of support from, and connection with other group members

Group member's agreement for confidentiality

All members of the group will be asked to agree to a high level of confidentiality in the group sessions. This means that each participant agrees not to share any other group member's identifying and personal information with others. It is appropriate to share with others your personal reaction and feelings about group, but refrain from sharing other people's stories with others who are outside of the group.

Your Group Facilitator and the Therapeutic Relationship

Your group facilitator is John Mark Krejci, Ph.D., who is a licensed Psychologist in the state of California (PSY25094).

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The relationship between you and your group facilitator is special and unique. You will be sharing sensitive information in group. With time, you may come to feel close to other members as well as to your facilitator and may wish to spend time with them in a more social environment. However, in order to protect your confidentiality and maintain professionalism, group facilitators and group members do not socialize together. And, under no circumstances is it ever okay for a therapist or group facilitator to be romantically or sexual engaged with a client or group member.

The role of your group facilitator

The philosophy and approach to group therapy is the belief that this is *your* group. Each group member will have an equal say in what topics will be discussed and what format feels most beneficial. Your group facilitator's primary responsibility is to create an atmosphere of safety and support in order for you to get the most out of group. Your group facilitator will encourage each group member to be honest, vulnerable and respectful about his feelings and observations in the group. It is important that each individual's boundaries and limits are voiced and respected in the group. Thus, if you are ever feeling unsafe in group you are encouraged to discuss this with your group facilitator. If for any reason you experience any negative reactions or blocks towards participation, please share this with the group. Your voice is your power and right.

Benefits and Risks of Group Therapy

Participating in group therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improving interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. It is important to recognize that therapy is not magic, and change does not occur overnight. Your willingness to participate fully in group and your openness to take feedback from your facilitators and other group members will play a role in how much you gain in therapy. In particular, the extent to which you are open and honest about yourself will play a role in how quickly you can achieve your goals.

There can be discomfort involved in participating in group therapy. You may remember unpleasant events, or have aroused feelings of anger, fear, anxiety, depression, frustration, loneliness, helplessness, or other unpleasant feelings. If these distressful emotions arise during your therapy, you are encouraged to discuss your feelings with the group and with your group facilitator. This will help you effectively manage these feelings and identify additional support if necessary.

During the process of group therapy, it is normal to have intense feelings and reactions to other group members or even towards your group facilitators. Again, these are understandable emotions that should be discussed and processed in the group setting.

If you believe that group is not the most appropriate setting for you to heal and grow, you have several options available to you:

1. You can receive only individual therapy or group therapy as well as individual therapy
2. You can consider individual therapy with the group facilitator, another member of the Therapy Changes team, or from an outside referral
3. Your group facilitator can assist you in finding another group that is a better fit for your needs
4. In some cases your group facilitator might discuss with you the possibility of a psychiatric consultation

As part of your therapy, you are encouraged to see a medical physician for any physical or medical concerns that could be related to emotional difficulties.

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Limits of Confidentiality

In accordance with professional ethics and California law, the information revealed in group therapy is confidential, and will not be revealed to 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 in which a child is engaged in an obscene sexual act. If you are in danger to yourself, to others, to property of another person, or if you are gravely disabled your facilitator is mandated to make a report to the appropriate authorities. Your facilitator is also obligated to disclose information if a close family member communicates to the facilitator 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 facilitator may be required by a Court Order. Your facilitator will use his clinical judgment when revealing such information, and will do his 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 facilitator 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, receipts, appointment reminders, and private messages from your facilitator 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 facilitator 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 facilitator's email, is even more vulnerable to unauthorized access. Although your facilitator's emails are not encrypted, privacy measures are taken such as firewalls on your facilitator'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 facilitator. Engaging in this way can compromise your confidentiality.

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Phone contacts between sessions, although generally rare, can be utilized 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. If this is the case, you will be responsible for the full session amount. E-mail and phone communications are helpful tools for asking general questions of your facilitator, confirming meetings, and conveying relevant information and updates. However, e-mail and out-of-session phone contact should not be used as a substituted for therapy. Your facilitator will not conduct therapy via email. In such cases that lengthy or disclosing emails are received, your facilitator will invite you to a conversation in the office.

Please notify your facilitator if you decide to avoid or limit, in any way, the use of secure messaging or E-mail. Otherwise, your facilitator 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 facilitator 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 facilitator'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 facilitator is known to contribute to the effectiveness of therapy.

Friending and following

Your group facilitator 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 facilitator. Rather, these accounts are associated with the practice and allow public access to blog posts and relevant news and community resources. Group participants 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 facilitator 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 facilitator. 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 therapy, online business review sites such as Yelp pose a unique challenge for both the facilitator and client. Therapy Changes or your individual facilitator 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 facilitator to solicit a testimonial from a current or former client. If you post an online review based on your experience in therapy, you are publicly acknowledging a facilitator-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 facilitator cannot respond to any review on a business review site for

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confidentiality reasons. Thus, you are encouraged to share your comments – either positive or negative directly with your facilitator. Your facilitator 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 facilitator'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 facilitator ever resorts to such means, he will fully document and discuss this with you at your next session.

Emergencies

The Therapy Changes office does **not** offer emergency services. 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 facilitator within 24 hours.

Fees

Insurance reimbursement

Claims (mental health invoices) may be submitted to your insurance company on your behalf for services rendered. You may be responsible for a co-payment amount or deductible amount. This amount varies depending on the type of policy that you carry with your insurance company. On the first Saturday of each month, your group facilitator will collect your co-payment or deductibles for each session held during that month, either four or five sessions in total. Payment can be made by debit or credit card, cash or check payable to 'Therapy Changes.' We accept debit and credit cards, cash or check payable to 'Therapy Changes'.

Client Initials: ______ Facilitator Initials: ______

Group therapy is not recognized by all insurance plans and may be considered a non-covered service. Not all issues, conditions, or problems are reimbursed by insurance companies. Although we do our best to verify your eligibility for mental health services, Therapy Changes is **not** responsible for denied claims. <u>In the event that a claim is denied, you are personally responsible for the full invoice amount</u>.

Client Initials: ______ Facilitator Initials: ______

It is your responsibility to understand your mental health services coverage with your insurance. You are advised to seek assistance in understanding your mental health benefits by contacting the Human Resources Department with your employer or by calling the 'Member Services' number on the back of your card.

Changes in your insurance plan or coverage

Changes in your insurance company or insurance coverage (such as annual renewal, expiration or type of coverage provided) may affect your financial responsibility. <u>Please notify your facilitator if you change your insurance plan or anticipate a change in your coverage.</u>

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Fee for service arrangements

If you are not using insurance, or if a claim has been denied, the fee for group therapy is $50.00 per session. On the first Saturday of each month, your group facilitator will collect $50.00 for each session held during that month, either $200.00 or $250.00 in total. Payment can be made by debit or credit card, cash or check payable to 'Therapy Changes.'

Client Initials: ______ Facilitator Initials: ______

As the administrative costs of running a practice change, session fees may be adjusted accordingly. In such cases, your facilitator will discuss the adjusted fee with you at least 30 days before a change will come into effect.

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 on a monthly basis. You have the option to submit Superbill statements to your insurance company for possible partial reimbursement.

Credit card on file

If you use a credit card, <u>your credit card will be saved on file through our secure practice software</u>. You will have the option to pay via your credit card on file on the first Saturday of each month. Please inform your facilitator if you do not want your credit card on file to be processed in this manner. Refer to the *'electronic communications'* section of this document for privacy information.

Client Initials: ______ Facilitator Initials: ______

Returned checks

In the event that a deposited check is returned due to insufficient funds ("bounced" checks), a $50.00 fee will be charged. In addition, you will be responsible for the original amount owed. If such situations arise, you may be asked to pay either with a credit card or cash for subsequent sessions.

Client Initials: ______ Facilitator Initials: ______

Time spent on your behalf

In addition to the time spent in the office, time spent on your behalf may be charged full fee including, but not limited to: consultations with other treatment providers, reading or writing documents, formal assessments, research, meetings with others, and report writing. Typically <u>any time exceeding 20 minutes outside of the regularly scheduled sessions is subject to the full session fee.</u>

Client Initials: ______ Facilitator Initials: ______

Missed group sessions and late cancellations

If you are unable to attend a group session during the month ahead, you must notify your facilitator either via email or phone <u>within 48 hours of the first Saturday of the month</u> and you will be charged only for the sessions that you will attend during that month.

<u>No refunds are offered</u> for missed group sessions without providing notice within 48 hours of the first Saturday of the month.

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You are required to provide credit card information and authorization for your facilitator to charge your card automatically in the case of missed sessions or late cancellations. A receipt for each payment is available upon request.

Please complete:

I, _________________________, (credit card holder's full name) authorize Therapy Changes to charge my credit card, indicated below, the amount of $50.00 * in the event of a missed scheduled session or cancellation of a scheduled session with less than 48 hours' notice.

Billing Address: ____
Street City State Zip

Phone#: ________________________________ Email: _______________________________________

*This amount is the agreed upon fee for services (if not using insurance), or the allowable amount set forth by your insurance company. Fees and allowable amounts are subject to change. You will be notified of any changes to this amount either by your therapist or a member of the Therapy Changes administrative team.

Credit Card Information:

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Account Number: ____ Expiration Date: __________

Cardholder Name: ___________________________________ Security Code (CVV): ____________

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

Signature ____ Date ____________________

Other Office Policies

Consistent Attendance

It is very important that you consistently attend and arrive on time to your group therapy sessions. Although illness, unexpected events, or vacations may occasionally interrupt your therapy, consistent attendance plays a large role in helping you, and your fellow group members achieve your desired goals. Please be aware that arriving late or being absent negatively influences the progress of yourself and the other group members. If for any reason you are not able to attend a group session, please inform your group facilitator.

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.

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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 facilitator individually to discuss your treatment goals and determine whether it would be clinically appropriate and beneficial to bring your Service Animal to your session.

Client Initials: ______ Facilitator Initials: ______

Conclusion of group therapy

There are many different levels of care that facilitators provide. Although group therapy is a very helpful tool for many people, the level of care offered at Therapy Changes and with this group may sometimes not be the best match to a participant's needs. If at any point during therapy your facilitator assesses that he is not effective in helping you reach your goals in the group setting, he will provide you with a number of referrals that may be of help to you. We ask that you have the group at least **two week** notice when you are ready to leave the group and that you attend group sessions during this time in order to say goodbye fully.

In the event that your facilitator is suddenly unable to continue to provide professional services or maintain client records due to incapacitation or death, he has designated a trusted professional colleague to be his professional executor. Your facilitator's professional executor will be given access to your file and may contact you directly if such a circumstance should occur. Your facilitator'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 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 group therapy.

____ ______________________

Signature of Client Date

____

Printed Name of Client

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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

You may refuse to sign this acknowledgement

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 providers who provide you with health care services or are involved in your case. For

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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.

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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.