CLIENT REGISTRATION

Today's Date:	

CLIENT INFORMATION

First Name: Middle Name: Last Name:	Preferred Name	Marital status

Street Address:	City:	State:	ZIP Code:

Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	Birth Date (MM/DD/YYYY):	Gender: ❑ M ❑ F
Do NOT leave a voice mail Do NOT mention "Agape Recovery Center"	Do NOT leave a voice mail Do NOT mention "Agape Recovery Center" Do NOT send text message reminders	Do NOT leave a voice mail Do NOT mention "Agape Recovery Center"	Email Address Permission to contact you via e-mail?	

Employer or Current School: Occupation (or Grade Level):

How did you hear about Agape Recovery Center?

May we contact your primary care physician?	If yes, Name of Primary Care Physician	Contact no.: ( )

IN CASE OF EMERGENCY

Emergency Contact Name:	Phone Number: ( )	Relationship to client:

PARENT / GUARDIAN INFORMATION (for minor patients)

Full Name: Guardian Contact Number: ( )

INSURANCE INFORMATION

Last Name **(if different):** First: Middle:

Insurance Company:

Primary Insured Birth date: Primary Insured Phone Number: ( )

Policy no.: Group no.:	Insurance phone no.: ( ) Relationship to insured:

*** PLEASE NOTE: 24 HOUR CANCELLATION POLICY – Please be advised that 24 hours notice is required for cancellations. Otherwise, your account will be charged a fee for the session.** The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize those acting on Agape Recovery Center's behalf, and my insurance company to release any information required to process my claims. Thank you for your cooperation.

Client Signature: Guardian Signature:

FINANCIAL AGREEMENT

Client Name: Date of Birth:

Please select how you will be paying:

Pay a reduced rate of $ due to financial need

Pay regular Rate

Please Initial

Cancellation Policy: I understand that when I make an appointment with Angie Matthews, LCSW, LCASA, this time is held specifically and no one else is schedule during this time. I agree that if I need to cancel my appointment, I will call Angie Matthews, LCSW, LCASA 24 hours in advance of my appointment. I understand that this cancellation policy does not pertain to crisis situations such as a car accident or illness requiring hospitalization.

No-Show Fee / Late Cancellation Fee: I understand that I will be charged a fee of $50.00 for cancellations less than 24 hours before my appointment or for no shows.

I may revoke this authorization at any time by giving written notice to Angie Matthews, LCSW, LCASA. I understand that revocation of payment authorization shall not affect payments prior to the revocation to the extent that this Authorization was replied upon for payments authorized prior to the revocation. By signing below, I agree that I understand, acknowledge and agree to the financial policies with Angie Matthews, LCSW, LCASA.

____ _____________

Signature: Today's Date:

Client Name: Date of Birth:

CREDIT CARD AGREEMENT

In the event that I cancel an appointment within 24 hours or fail to attend a scheduled appointment I hereby authorize Agape Recovery Center to charge to my credit card the fee of $50

Name as it appears on Card:

Credit Card #:

Exp. Date:

CVV:

Billing Address of Credit Card:

Street City/State Zip Code

-

Date:

Signature:

CONSENT TO RELEASE INFORMATION

CLIENT NAME DOB:

I authorize and request Agape Recovery Center to release information and/or exchange information from the medical records of the client listed above to:
the following individuals or organizations:

____

for the purpose of assessment, collaboration, consultation, treatment planning, referral, and/or any coordination of mental health services.

Please indicate which documentation regarding your treatment may be released and/or exchanged. Release of information is limited to the minimum necessary to accomplish the purpose for which the request is made.

Information contained in the client's medical record related to psychotherapy, diagnosis, status, symptoms, prognosis, treatment, and discharge.

Information contained in the client's medical record related to treatment for alcohol and/or drug abuse/use.

Information contained in the client's medical record related to treatment for HIV/AIDS

THE INFORMATION TO BE DISCLOSED WILL BE USED FOR THE FOLLOWING PURPOSE:

Sharing with other health care providers as needed

Other (describe): ____

This Authorization shall cover actions by and for Agape Recovery Center and all of their respective employees, workforce, and business associates. This Authorization may be revoked at any time, provided the revocation is a properly executed written document and delivered to Angie Matthews, LCSW, LCASA (see address below). Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation. I understand that once the information is disclosed, it may be disclosed by the recipient and federal and/or state privacy laws may not protect the disclosure. I understand authorizing the disclosure of information identified above is voluntary and this Authorization is not intended to alter the client's ability to receive medical care from any health care provider.

This authorization will expire on the following date or event:
If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

I understand that I may refuse to sign this authorization form and understand that Angie Matthews, LCSW, LCASA will not alter my treatment or any payment if I refuse to sign.

____

Date ***Signature of Client/Parent/Legal Representative

**If the client is under 18 years of age, unless the client is an emancipated minor, this Authorization (and any revocation) must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the minor client's behalf. By signing this form for someone else, you as the parent, guardian, a party acting in loco parentis, or legal representative warrant that you have the legal authority to act on the client's behalf and that you are not prohibited by Court Order from having access to the requested medical records.

THE INFORMATION RELEASED IS CONFIDENTIAL AND REDISCLOSURE IS PROHIBITED
EXCEPT AS AUTHORIZED BY G.S. 122C:53 THROUGH G.S. 122C:56

Therapist Professional Disclosure

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the NC Notice Form) for use and disclosure of PHI for treatment, payment and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information.

MENTAL HEALTH SERVICES

I am a Licensed Clinical Social Worker who has been providing education and practicing social work/mental health for over 20 years. I have a Bachelor of Arts in Social Work from Rutgers University. I also earned a Masters in Art of Religion with a concentration in Pastoral Counseling at Liberty University and I am currently fully provisionally licensed as a Licensed Clinical Addictions Specialist. I work with teenagers and adults individually, in families, and in groups. If the problems you or your family experience is outside of my expertise, I will assist you with appropriate referrals to other professionals. Mental health treatment can have benefits and risks. You may experience uncomfortable and possibly intense emotions. However, treatment often leads to better relationships, solutions to problems, and reductions in feelings of distress. There are, however, no guarantees of what you will experience.

Our first session consists of an assessment/intake process, as well as an evaluation of your needs. Our second session will consist of the development of your treatment plan. Sessions can last anywhere from 30 minutes to 60 minutes. At any time, I will be happy to help you set up a consultation with another mental health professional for a referral or a second opinion.

For Clinical Assessment clients: Our session consists of a comprehensive clinical assessment (CCA) which is a detailed evaluation of your history from a holistic point of view and which evaluates your current mental health needs. The CCA will also determine if you meet the criteria necessary to engage in Enhanced Benefits services, such as Intensive In Home or Community Support services. This assessment will usually last around 2 hours.

OPT SESSIONS

After the assessment phase of approximately 2 to 4 sessions, I usually schedule one session (one session=30 to 60 minutes) per week at a time we agree on, although some sessions may be longer or more frequent. Please understand that regular clients are usually scheduled the same time and day each week.

CCA SESSION

A Comprehensive Clinical Assessment (CCA) is conducted in one session and can last approximately 2 hours. If you have been referred for a CCA from an outside referral source, I will send the results of the CCA to them and they will manage your treatment from that point. If your referral source has referred you for OPT and a CCA, we can schedule your OPT sessions immediately and conduct the CCA within one of our first sessions. If you would like a referral to another mental health professional for OPT, please let me know, and I would be happy to help you link to another professional.

OPT/CCA CANCELLATIONS

Once we book your session, I hold this time for you and do not schedule anyone else in your time space. If you need to cancel, please give me the courtesy of providing 24 hours notice of cancellation. If you are late, we will still end at the regularly scheduled time.

OPT/CCA PROFESSIONAL FEES

Other Insurance/Private Pay clients: Payment for services can be made by cash, check, or credit card. We do not bill for your mental health services, but we will assist you in any way possible and give you a "super bill" which you can submit to your insurance company for possible reimbursement. Please check with your insurance company in advance to see if they will cover any of your costs for treatment. If you do need to cancel any appointment, please ensure that you provide 24 hours' notice, unless it is an emergency. If you do not provide sufficient notice, there will be a charge of $50.

Fees are as follows: Initial Intake: 150.00 per intake; Hourly rate: 100.00; Telephone conversations > 10 minutes: 50.00 per hour, prorated; If you become involved in legal proceedings that require or force my participation, you will be expected to pay for all of my professional time in increments of 4 hours. That would include preparation and transportation costs, even if I am called to testify by another party. As a result of the difficulty of legal involvement, I charge $250.00 per hour portal to portal for preparation, transportation and attendance at any legal proceeding. This cost is not reimbursable through insurance plans.

OPT CONTACTING ME

I am in session frequently, and I am often not immediately available by telephone. I do not answer the phone when I am with clients. My telephone is answered by an automated, confidential voicemail which I monitor frequently. I will make every effort to return your call on the same day you make it. If you call and have not heard from me within a day of your call, I may not have received your initial message, so please call back in that case. Please do not leave urgent or emergency messages on my phone, as I may not be able to respond to your phone call in the time that is needed by you. Therefore, **if you are unable to reach me immediately and feel that the situation is an emergency, hang up and dial 911.**

If it is an urgent situation and you feel you cannot wait for my return call, you may: 1.) Contact your family physician 2.) Have someone take you to the nearest emergency room and ask for the psychiatrist on call or 3.) Call the Holly Hill Hospital Respond Line at 919.250.7000. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

HIPPA/LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a Licensed Professional Counselor. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this document provides consent for those activities, as follows:

1. I may occasionally find it helpful to consult other health and mental health professionals. I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.
2. You should be aware that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes. Staff has been trained about protecting your privacy and has agreed not to release any information outside of the practice without my permission.
3. I may elect to have contracts with an accountant and an attorney. I also hold a contract with a malpractice insurance company. As required by HIPAA, we have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this practice data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.
4. Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
5. If I believe that a client presents an imminent danger to his/her health or safety, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

1. If you are involved in a court proceeding and a request is made for information concerning the professional services that I provided you, such information is protected by the counselor client privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
3. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
4. If a client files a worker's compensation claim, and my services are being compensated through workers compensation benefits, I must, upon appropriate request, provide a copy of the client's record to the patient's employer or the North Carolina Industrial Commission.

There are some situations in which I am legally obligated to take action, which I believe are necessary to attempt to protect others from harm and where I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

1. If I have cause to suspect that a child under 18 is abused or neglected, or if I have reasonable cause to believe that a disabled adult is in need of protective services, the law requires that I file a report with the County Director of Social Services. Once such a report is filed, I may be required to provide additional information.
2. If I believe that a client presents an imminent danger to the health and safety of another, I may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.

If any of these situations arise, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future.

CLIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in your Clinical Record and I will keep this record secured for the length of time based on NASW guidelines. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and/or others or the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

MINORS & PARENTS

I respect the right of children to independently consent to and receive mental health treatment and to have a "safe and protected space" in therapy. However, parental involvement is also essential to successful treatment and this requires that some private information

disclosed by a child or teen be shared with parents. It is my policy not to provide treatment to a child or teen under 16 unless he/she agrees that I can share whatever information I consider necessary with his/her parents. For teens 16 and over, I request agreement with my client allowing me to share general information about the progress of the teen's treatment. I expect parents or guardians to respect that overall communication between myself as therapist and their child/teen/ward is confidential. The exception would be if I believe that the child is in danger or is a danger to someone else. In such a case, I will notify the parents of my concern and the law requires me to report this to the proper authorities. Before giving parents any information, I will discuss the matter with the child or teen, if possible, and do my best to handle any objections he/she may have. In situations involving separated or divorced families, the person who initiates services for a child is the person responsible for payment, regardless of any other arrangement made with the exDspouse. Further, it is important for separated or divorced families to understand that when their teenagers or children are in therapy, the minor needs to be able to process their thoughts and feelings without risk of having their personal thoughts/opinions/feelings exposed in court during a custody battle. With this, I do not work with families who: 1.) Bring their children or teenagers to therapy while in the middle of or contemplating a court/custody proceeding, 2.) Endeavor to gain custody or gain favor in the court's eyes by utilizing the minor child's therapy records in court, 3.) Desire to prove the inadequacy to the court of the other parent or, 4.) Want to utilize their child's therapy records to present to the court for the benefit of custody or other court matters. I will be more than happy to work with your child or your family after your current legal proceeding is complete. I will consider working with a family who is involved in a court proceeding only if each parent agrees to the child entering therapy, participates in the child's treatment to some degree, and both sign documentation attesting that they will not involve the child's therapy and/or myself in court, purposefully and/or inadvertently request the court to request or subpoena the child's records, sabotage the child's therapy in any form, request or force my testimony, or request or force any information related to the child's therapy. If I am forced into legal proceedings, I will make it clearly known to the judge that these guidelines were discussed and agreed upon and will speak with the judge regarding the parent blatant disregard for the safe and protected space of the child's therapy and the negative impact this would have on the child's welfare.

BILLING AND PAYMENTS

Currently, I accept cash and check. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment. Any returned checks will be charged a fee of $40. Payment for services will be collected prior to the start of the session.

INSURANCE REIMBURSEMENT

I am considered an "out of network" licensed mental health provider for all insurance companies and there is no guarantee that your insurance will pay partial or full benefits for my services. If you have questions about the coverage, call your plan administrator.

Thank you for taking the time to read through this professional disclosure. If you have any questions, please feel free to ask. I look forward to working with you!

REPORTING COMPLAINTS OR CONCERNS

If you are not satisfied with the counseling services offered to you, please contact me immediately. I will work diligently to resolve your concerns. However, if you think you have been mistreated or treated unethically, you may contact the North Carolina Social Work Certification and Licensure Board at Post Office Box 1043 in Asheboro North Carolina 27204. The phone number is (336)625-1679.

Acknowledgement

Your signature below indicates that you have been provided a copy of Angie Matthews's professional disclosure statement, which notifies you of limitations of confidentiality, procedures for reporting complaints, therapist's educational background and experience, and other policies and procedures.

Client's Name:

Signature: **Today's Date:**

CLIENT NAME: Date of Birth:

HIPAA Privacy Practices & Consent

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

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

• Make sure that protected health information ("PHI") that identifies you is kept private.

• Give you this notice of my legal duties and privacy practices with respect to health information.

• Follow the terms of the notice that is currently in effect.

• I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by

someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For my use in treating you.

b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.

c. For my use in defending myself in legal proceedings instituted by you.

d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

e. Required by law and the use or disclosure is limited to the requirements of such law.

f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

g. Required by a coroner who is performing duties authorized by law.

h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AURTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate 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 emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

____________________________________ ______________

Client/guardian/representative signature Date

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Angie Matthews, LCSW, LCASA