Client Intake Form

Rebecca Phipps, MA, LPS, CCPS 4300
Punjab Way, Unit #140, Frisco, TX 75033

Name: (please print) _____ Birth Date: _____

Address: _____ City/State/Zip Code: _____

Phone Number: _____ Email Address: _____

Presenting Problem

Describe the issue that brought you here today?

_____

When did the issue start and then become worse?

_____

What results are you seeking? _____

Please check all the behaviors and symptoms that you consider problematic, and you have experienced in the **last 2 weeks**:

	Trouble Concentrating		Change of appetite		Sleep issues
	Hyperactivity		Lack of motivation		Rapid thoughts
	Impulsivity		Withdrawal from people		Excessive energy
	Repetitive thoughts/behaviors		Excessive anxiety/worry		Wide mood swings
	Poor memory/confusion		Panic attacks		Obsessive thoughts
	Boredom		Fear away from home		Compulsive behavior
	Sadness/depression		Social discomfort		Suspicion
	Loss of pleasure/interest		Irritability/anger		Gambling problems
	Hopelessness		Frequent arguments		Computer addiction
	Homicidal thoughts		Aggression/fights		Pornography
	Self-harm behaviors		Hearing voices		Parenting problems
	Crying spells		Visual hallucinations		Sexual problems
	Loneliness		Nightmares		Relationship problems
	Low self-worth		Flashbacks		Work/school problems
	Guilt/shame		Trembling		Alcohol/drug use/overuse
	Fatigue		Other:		Other:

Parent (s) of an underage child seeking services: Bothe parents are required to sign all signature forms. If divorced and have legal custody, the divorce decree must be presented that the parent bringing the child has the right to medical decisions for the child. If not available, the appointment will be rescheduled until produced.

Describe your sleep in the last 24 hours: _____

Describe your eating habits: ___ Decreased appetite ____ Overeating ___ Healthy ____ Diet Plan

	Daily Task		Physical activities		Relationships		Hygiene
	Work		Housing		Legal matters		Finances
	Self Esteem		Sexual activity		Unplanned Pregnancy		Health

Do you have current thoughts of wanting to hurt yourself or someone else? _____ No _____ Yes

Have you been hospitalized in the past for wanting to hurt yourself or someone else? _____No _____Yes

If yes, explain: _____

Personal and Family History

Relationships	Name	Age	Quality of this Relationship
Mother			
Father			
Stepmother			
Stepfather			
Sibling			
Sibling			
Sibling			
Sibling			
Spouse/Partner			
Ex-Partner			
Children			

Family Mental Health History -Diagnosed	Who?
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	

Family Mental Health (con-d)	**Who?**
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

Parents Relationship (check all that apply)

____Parents legally married or living together ____ Parents Divorced ____Parents Separated
____ Mother Remarried ____ Father Remarried _____Mother Unknown _____ Father Unknown
____ Mother Deceased _____ Father Deceased ____Relationship with Mother/Father

Trauma and Loss

Check if you have experienced any of the following types of trauma or loss:

	Emotional abuse		Neglect		Living in a foster home
	Sexual abuse		Violence in the home		Multiple family moves
	Physical abuse		Crime victim		Homelessness
	Parent substance abuse		Parent illness		Loss of a loved one
	Teen pregnancy		Placed a child for adoption		Financial problems
	Abortion		Betrayal		Combat

Previous Mental Health Treatment

List any previous Counseling or Drug/Alcohol treatment you have received.

When? _____ Provider? _____ Reason? _____

When? _____ Provider? _____ Reason? _____

Substance Use History

Substance Type	Y	N	Current		Y	N	Past	
			Frequency	Amount			Frequency	Amount
Tobacco /Vaping								
Caffeine								
Alcohol								

Marijuana								
Cocaine/Crack								
Ecstasy/ Heron								
Substance Type (con-d)	**Y**	**N**	**Present Frequency**	**Amount**	**Y**	**N**	**Past Frequency**	**Amount**
Inhalants/Steroids								
Methamphetamines								
Tranquilizers/Pain Killers								

Have you had any withdrawal symptoms when trying to stop using any substance? _____No _____Yes.
Have you ever had any problems with work, relationships, health, the law, due to substance use? _____ No ____Yes

Medical Information

Have you ever experienced any of the following medical conditions?

	Allergies		Asthma		Headaches		Stomach aches
	Chronic Pain		Surgery		Serious accident		Head injury
	Dizziness/fainting		Meningitis		Seizures		Vision problems
	High fevers		Diabetes		Hearing problems		Miscarriage
	STD		Abortion		Sleep disorder		Other:

Name and address of Primary Care Physician: _____

_____

List below any prescription medication you are currently taking, the prescriber, and reason prescribed:

_____

_____

Miscellaneous Information

Have you ever been convicted of a misdemeanor or a felony? ____ Yes ____ No
If yes, explain: _____

Are you currently involved in any Divorce or Child Custody proceedings? ____ Yes ____ No
If yes, expain_____

Who is part of your support network? Family _____ Neighbors: _____ Friends: _____ Co-workers: _____ Other:

Do you participate in religious or spiritual practice? _____No _____ Yes How would you describe yourself? _____

Information for Clients/Clients Rights

Relationship Counseling recognizes the client's right to privacy and protects all clinical service records from unauthorized disclosures. To provide you with the best possible service, there will be times when your counselor will need to discuss your case with a supervisor. Information about you will not be shared with anyone unless you give permission to do so.

You need to know that the law makes provisions for certain situations that cannot be kept private:

1. Concern that harm has been done to a child or an elderly person.
2. Concern that you may be planning to hurt yourself or someone else.
3. A subpoena to testify in court.

Client Rights

As a client you have certain rights that we acknowledge and respect:
1. To be treated with respect and dignity.
2. To receive competent, professional services.
3. To receive the full range of services as described in the initial intake.
4. To be free from acts of discrimination (as defined by law).
5. To be free to pursue grievances without the loss of services.
6. To participate in the development of a service plan.
7. To refuse service.
8. To request a different service provider.

Client Satisfaction

If you are dissatisfied with the services, you receive we ask you to follow these steps.
1. Talk to your counselor about your concern and try to develop a plan that better meets your needs.
2. Write a written letter of grievance to the therapist and satisfy resolution achieved.
3. Contact the Texas State Board of Examiners of Professional Counselors, P.O. Box 141379, Ausin, TX 787141369.

Client Responsibilities

Certain behavior is expected from our clients. Failure to assume the following client responsibilities could result in the discontinuation of service.

1. To treat the counselor and other clients with respect including respect for their physical safety.
2. To provide accurate and helpful information.
3. To cooperate and participate in the client service plan while adhering to expectations.
4. To refrain from illegal activity on the site property.

Hours of Service

Appointments need to be made in advance whenever possible. Evening hours are available. Arrangements to contact this office can be done by utilizing the telephone number provided to you. Rev 11/24

Rebecca Phipps, MA, LPC, CCPS
Consent for Services

I acknowledge that I received, have read (or have had read to me) and understand the "Information for Clients" and other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will be responsible for is paying for the services I have already received. I understand that I may lose services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for the standard office no show fee of $75.00.

I am aware that an agent of my insurance company or other third-party payer may be given information verbally/electronically/written about the type(s), cost(s), date(s) and provider of any services or treatment I receive.

I understand that any communication through electronic mediums, including texting, and other social media outlets, is not secure. If contact is sent via email or text this provider cannot guarantee that these methods of communication are secure.

I understand that telehealth/teletherapy/online therapy laws protect confidentiality of medical information in the office and in telehealth sessions with permissive exceptions to confidentiality. Both I and the therapist/counselor agree to privacy safeguards during and in person sessions There is a risk to being overheard by a third party if you do not conduct the session in a private room with reasonable sound protection and with no one else present or observing. I agree not to record any session and the right to not use telehealth sessions at any time.

I understand that no electronic transmission is completely safe from intrusions and interruptions by third parties and that remains technically possible. Due to the complexities of electronic media and the internet, there can be a risk. I understand I am responsible for information security on my own device(s) and am responsible for my own device, hardware, software, audio, video, and internet connection.
I understand if there is a disruption in service we may reconnect and try again. I understand that, if necessary, we may have a telephone session if there is a technical malfunction.

I understand that copay, deductibles, out of pocket payment for the all services in person, and via telehealth services are paid at the time service is provided. If for any reason payment is not received, services will be discontinued until payment for services are received.

My signature below shows that I understand, discussed questions, am satisfied, and agree with all the statements above.

_____ _____

Client Signature Date

Rebecca Phipps, MA, LPC, CCPS
Authorization Release of Information
(Health Insurance)

I do consent and authorize Faith Behavioral Health Group to release all information contained in my financial and medical record, including diagnoses result, to my health insurance company or health plan, their agents, contractors or any third-party entity that is responsible for paying or processing any portion of my service bill for the purpose of administration, billing and quality and risk management. This consent applies to all records created during my treatment and for the purpose of reimbursement for treatment rendered.

I understand I can revoke this consent at any time by giving a written notice to Faith Behavioral Health/ Rebecca Phipps, MA, LPC, CCPS except to the extent that the action has been taken before receiving the written request to revoke the authorization. If no prior notice of revocation is received, this signed consent will expire in six months after the date of my discharge from treatment, unless another date is specified.

I understand that I have a right to inspect and copy information to be disclosed.

I understand that if I refuse to consent to this Release of Information, the results will be that the health insurance billing claim will not be filed.

_____ _____

Client Signature Date

_____ _____

Guardian/Parent's Signature Date

Notice to Receiving Person/Agency

This information is disclosed to you from records protected by the federal Confidently Rules (42 CFR Part2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part2. A general authorization for the release of medical information is not sufficient for this purpose.

Rebecca Phipps, MA, LPC, CCPS

Social Media/Email

This document outlines office policies - Social Media – Written Documentation (Read and sign below)

Social Media Interacting

Please do not use SMS (Mobile Phone Text Messaging or Social Networking sites such as Twitter, Facebook or Linked in to connect with me. These sites are not secure, and I may not read these messages in a timely fashion. Do not use postings, or any other means of engaging with me online if we have an already established client, therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of legal medical records and will need to be documented and archived in your chart. I do not engage in any requests from current of former clients on any social media sites (Facebook, linked in) as that can compromise your confidentiality and respective privacy. If you need to contact me between sessions call the office phone number.

Email

I prefer using email only to arrange or modify appointments. Please do not email me content related to your therapy session, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your Internet Service Providers. While it is unlikely that someone will be looking at these logs, they are in theory available to be read by the system administrator of the Internet Service Provider. You should also know that any emails I receive from you and any response that I send to you, become part of your legal record.

_____

Documentation

I understand that this therapist does not fill out FMLA, or disability paperwork.

I understand this therapist does not write support animal letters.

I understand this therapist does not appear in court to defend clients. If for any reason there is a subpoena, the client will pay $1,500 for each half day in court. Payment will be collected in advance.

I understand this therapist does not do any mental evaluation for court cases.

I understand any written letters/written requests will be charged a standard office fee for time occurred.

_____ _____ Client

Signature Date rev.8/ 23

PROFESSIONAL DISCLOSURE STATEMENT

Rebecca A. Phipps, MA, LPC
Faith Behavioral Health

4300 Punjab Way, # 140, Frisco, Texas, 75033
Phone:(469) 530-2244 Fax: (469) 530-804-9311

Philosophy & Approach to Counseling: As a counseling practitioner, I aspire to the following view: I believe the essence of counseling is to look at the total person. I believe that people are comprised of Body, Mind, and Spirit and together, these components account for one's psychological, emotional, and spiritual wellbeing. I see myself as a facilitator in the counseling process. I view the therapy process as a collaborative effort as I walk cooperatively alongside clients, as treatment goals are established, options are explored and, in this process, encourage the changes that are necessary to achieve treatment goals. I will incorporate a wide variety of therapy techniques as I recognize each client is a unique individual. I use evidence-based approaches and will discuss spiritual matters in the counseling process with the consent of my clients. I closely subscribe to Cognitive Behavioral Therapy (CBT), Strength Based/ Solution Focused Therapy, Family Systems, Dialectical Behavioral, Eye Movement Desensitization (EMDR) and Mindfulness.

Formal Education, Training & Experience: I am a graduate of the George Fox University Counseling Department and hold a Master of Arts Degree in Counseling**.** I have an undergraduate degree in Business & Communication (WBC-Corbin University). I am certified as a paralegal (National University) and in Human Resource Management (Portland State University). I am a certified educator under the Gottman Institute of BBH and trained under Dr. John Gottman in Couples Therapy, Assessments, Intervention & Co-Morbidities - Level 1 and 2. I am a Certified Clinical Partner Specialist (APSATS) trauma model and an EMDR (EMDRIA) trained therapist. My experience includes working with diverse populations, supervision, training, mentoring, and counseling individuals, couples, and families. To maintain my license and maintain and enhance my professional skills, I am required to participate in continuing education, taking classes dealing with subjects relevant to this profession as well as courses on ethics and cultural diversity.

Counseling Relationship: Our relationship is a professional and therapeutic relationship. To preserve this relationship and abide by the Texas Board of Professional Examiner and Counselors (681.32 Texas Administrative Code, chapter- 681), it is imperative that the therapist refrain from any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of therapeutic relationships. Gifts, bartering, and trading services are not appropriate and should not be shared between you and the therapist. Other than a chance meeting, our contact will be a counseling relationship.

Effects of Counseling: You have the right to discuss positive or negative effects of entering, not entering, continuing, or discontinuing counseling. Counseling is beneficial and yet results are not guaranteed. Counseling is a personal experience and in the process of change, you may experience new life changes. Some of these changes may include new insights regarding your home life, work life, relationship with others, circumstance, and your future. The desire in therapy is that your concerns and challenges will be seen and resolved in a way that you achieve success. The exact nature of these changes cannot be predicted but we will work together to achieve the best possible results for you. In case you experience a mental health emergency, immediately dial 911 and/or go to a nearby hospital emergency room.

Fees for Services: A standard $150.00 fee is offered for a 50-minute session and $170.00 for couples. Various Managed Health Care Insurance is accepted and paid on a standard professional time and fee schedule. A sliding scale is available for those in need and is set per gross income. If I provide service and use insurance, your insurance will be billed from Faith Behavioral Health. If you choose to pay out of pocket and be reimbursed by your insurance company, they will require that it is a medical necessity, and you will need a mental health diagnosis. All payments are due at the time services are rendered. If you arrive more than 15 minutes late for a session your appointment may be rescheduled.

Cancellation Policy: A 24-hour cancellation notice is required for all scheduled appointment times. If an emergency occurs, you must call so others can be scheduled at your appointment time. If the 24-hour notice is not respected, you will be charged $75.00 for the missed appointment or the current office late fee. It is understood that at times an emergency can occur. If that occurs, the situation will be discussed on a case-by-case basis.

Client Rights: Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end the counseling relationship at any time, though I do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of our counseling techniques or suggestions that you believe might be harmful. I ascribe to the Code of Ethics of the American Counseling Association (ACA). The services that I offer will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with our services, please let me know so we can develop a plan that better meets your needs. If I am not able to resolve your concerns, you can write a letter of concern to 7616 Heritage Dr. Aubrey, TX 76227, and a consolation will be scheduled to have the issue discussed and a satisfactory resolution achieved. If the concern is still unresolved after that, you may report your complaints in writing to the Complaints Management and Investigation Section, Texas State Board of Examiners of Professional Counselors P.O. Box 141369 Austin, Texas 78714-1369 or by calling 1-800-942-5540 to obtain more information. A notice to clients is also displayed in the office.

Referrals: I recognize that not all conditions presented by clients may be appropriate for treatment with this counselor. For this reason, some other alternatives will be offered including programs, groups, or another specialist. Follow up with the referrals will be your responsibility.

Confidentiality: Treatment records remain confidential and will be released only with your written consent unless required by law. I will keep confidential the things you tell me with the following exceptions: (1)(a) you direct me to tell someone else, and I agree to do so; (b) I decide you are a danger to yourself or to others; (c) I am ordered by a court to disclose information; (2) you disclose abuse or neglect of a child or exploitation of the elderly or abuse of patient in a mental health facility (681.33 TAC, Ch. 681); (2) criminal prosecutions (611.004 Texas Health & Safety Code, Ch.611); (3) Child custody cases (611.006 Texas Health & Safety Code, 611); (4) situations where the therapist has a duty to disclose, or where in the therapist's judgement, it is necessary to warn or disclose (611.004 Texas Health & Safety Code, Ch. 611); (5) fee disputes between the therapist and the client (611.006 Texas Health & Safety Code, Ch. 611); or (6) the filing of a complaint with the licensing board (611.006 Texas Health & Safety Code, Ch. 611). If you have any questions regarding confidentiality, bring them to the attention of the counselor so you can discuss this matter further. Confidentiality also does not extend to criminal proceedings or to legitimate subpoenas in a civil proceeding. Patient records will not be released without written consent unless the court orders. A subpoena does not constitute a court order. Doctors/counselors do not appear in court to defend a client. If for any reason if subpoenaed, the client will be responsible for paying $1,500.00 for the half day or $3,000,00 for the full day in court. Payment will need to be collected in advance. (This includes time responding to subpoenas, depositions, time spent waiting to testify, driving time to and from the court, etc.)

There will be HIPPA compliant written or electronic record of our counseling sessions. Consultation and Supervision, as part of being an ethical therapist, from other professionals at times may be necessary.

By signing below, I authorized and agree to receive mental health care, treatment and counseling services from Rebecca Phipps, MA, LPC, CCPS. I also have read all sides of this form and understand all the contents in this document, and I understand my rights and responsibilities as a client.

_____ _____/_____/_____ Client's

Signature Date eff. 9/1//23

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical/mental health information about you may be used, disclosed and how you can get access to this information. Please review it carefully. If you do not understand any part, please ask for clarification.

Rebecca Phipps, MA, LPC, CCPS will hereby be known as RP, MA, LPC.

Duties of RP, MA, LPC:

The privacy and confidentiality of your health information is very important, and we are committed to protecting it to the extent we can, remaining consistent with the law and the ethical standards of the counseling profession. Your health information includes records that we create and obtain to provide care for you. For example, it includes a record of your symptoms, progress notes, diagnoses, summary of treatment consulting, and referrals as well as collecting payment, insurance claims and other billing information. This notice explains the different ways we may use and disclose your health information. It also describes your rights and responsibilities as a client.

RP, MA, LPC is required to:

1. Maintain the privacy of your protected health information (PHI) as required by law.
2. Provide you with this notice of our legal duties and privacy practices with respect to your health information that we collect and maintain.
3. Follow the terms of our notice that is currently in effect. a. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION – PAYMENT, TREATMENT, AND HEALTHCARE OPTIONS Under federal law, we are permitted to use and disclose personal health information without authorization for these purposes: providing treatment services, collecting payment, and healthcare operations. Treatment: Health information may be used to provide, manage, or coordinate care. Payment: Faith Behavioral Health insurance service biller and RPC, MA, LPC will submit claims to your health insurance company for payment. Only the minimum amount of information necessary for the insurance company to process the claim will be released. This may include diagnosis and explanation of care provided. Healthcare Operations: Which includes functions such as review of treatment procedures, certification, training, compliance, or licensing activities. 4. OTHER USES AND DISCLOSURES WITHOUT YOUR CONSENT Abuse, Neglect or Domestic Violence: I may disclose protected health information about you to a state or federal agency if required or permitted by law to report child or vulnerable adult abuse or neglect or domestic violence. When possible, and consistent with professional judgment to avoid harm to you or others, you will be informed if there is a need for such a disclosure. Business Associates: Faith Behavioral Health and RP, MA, LPC may disclose some or all your protected health information to business associates who perform services for this practice. All business associates need to safeguard any information they handle. When business associates are used at RCS only the minimum amount of information necessary is shared for them to perform their tasks. Judicial or Administrative Proceedings: I may disclose protected health information about you during a judicial or administrative proceeding as required by law. For example, if a court orders me to release information, I must generally comply with the order. In some circumstances, I may be required to turn over information in response to a subpoena. Law Enforcement: If authorized or required by law, I may release health information to law enforcement officials. Coroners, Medical Examiners, and Funeral Directors: In most circumstances, this counselor may disclose health information to a coroner or medical examiner to help identify a deceased person or determine cause of death. Health Oversight Activities: This counselor may disclose health

information about you to governmental, licensing, auditing, or healthcare accrediting agencies where authorized or required by law. Appointment Reminders and Other Health Services: You may be contacted as a reminder of appointments or other services/options. Communicable Diseases/Public Health Activities: To the extent authorized by law or ethical standards, I may disclose health information to a person who has been exposed to a communicable disease or who is at risk for spreading a disease. As required by law, health information may be disclosed about you to a public health agency. Prevention of Serious Threat to Public Health or Safety: In accordance with the law and professional ethics, I may use and disclose health information about you to prevent or minimize the risk of serious or imminent threat to your health and safety or the health and safety of another person or the public. Disaster Relief Efforts: We may disclose health information to government agencies or private organizations (e.g., Red Cross) to assist in disaster relief efforts such as notifying your family of your condition, status, and location. If you are unavailable (e.g., due to incapacity, injury) we will use our professional judgment as to what is appropriate in emergency circumstances. Communication with Friends and Family: We may disclose limited information about you to persons who are involved in your care, such as family members or close personal friends. Any such disclosure will be limited to information directly related to the person's involvement in your care. If you are unable to give consent (e.g., due to illness, injury, or emergency) we will use our best judgment as to what is in your best interest regarding disclosure. Minors: If you are an emancipated minor under the law in the state of Texas, we may, in certain circumstances, disclose health information about you to a parent, guardian or other authorized person, in accordance with the law and professional ethics. Parents: If you are the parent of a minor not emancipated, we may disclose health information about your child to you in certain circumstances. In other circumstances, such as when your child is legally authorized to consent to treatment without separate consent from you, and where the child does not request that you act as his/her personal representative, we may not disclose health/mental health information about your child to you without your child's authorization. Personal Representative: If you are an adult or an emancipated minor, we may disclose health information about you to a personal representative authorized to act on your behalf in making health care decisions. Research and Related Activities: We may disclose health information for research purposes in accordance with our legal and ethical obligations. Specialized Government Functions: We may disclose health information about you for specialized government functions as required by law. Required by Law: We may disclose health information about you when required to do so by federal, state, or other applicable law. 5. YOUR RIGHTS REGARDING HEALTH INFORMATION Right to Inspect Your Records: In general, you have the right to inspect and/or receive a copy of your records. A written request must be submitted to RP, MA, LPC, at 4300 Punjab Way, #140, Frisco, TX, 75033. You may be charged a fee for the cost of copying and mailing or summarizing your record. Right to Request an Amendment: If you believe the health information in our records is incorrect, you may request in writing that the information be amended or that an addendum be placed in the record. We cannot take out what is in the record, but we can add information. If your request cannot be granted, we will notify you in writing of the reason(s) for the denial and how you may appeal the decision, including your right to submit a statement disagreeing with the decision. This statement will become part of the record. Right to an Accounting of Disclosures: You have the right to receive a list of disclosures we have made of your health information. Right to Request Communication by Alternative Means: If you would like us to communicate with you in a certain way (e.g., by leaving a message on your home voice mail) or at a certain location (e.g., home), we will make every effort to accommodate your request for confidential communications if it is reasonable and practical to do so. Right to Request Restrictions on Uses and Disclosures of Your Healthcare Information: You have the right

to request that we restrict or limit certain uses or disclosures of information. This request must be submitted in writing. However, we are not required to agree with your request. You will be notified of the status of your request within 10 business days of receipt by this office. Right to Receive a Paper Copy of this Notice: You have the right to request a paper copy of this notice at any time, even if you have agreed to receive it electronically. 6. CONTACT INFORMATION All requests must be made in writing. After reviewing this notice, if you need further information or wish to contact me for any reason regarding your protected health information, please contact Rebecca Phipps, MA, LPC at (469) 530-2244. 7. QUESTIONS OR COMPLAINTS If you believe that your privacy rights have been violated, you may file a written complaint and address it to the person listed in Section 6. If that does not satisfy your concern about privacy, you may file a complaint with the Secretary of Health and Human Services, Ph: 1-800-363-1011. Instructions for filing a complaint with the appropriate office for your region can be found at http://www.hhs.gov/ocr/howtofileprivacy.pdf.

Notice of Privacy Practices

My signature below verifies I read and/or received by request the Notice of Privacy Practices.

_____ _____

Name Date

_____ _____

Guardian or Parent's Signature Date