Lifestyle Insight Therapy, LLC
Sarah Adair, MSW, LCSW, LSCSW
8300 College Blvd, Suite 320
Overland Park, KS 66210
(913) 338-0400

Welcome to my practice! This form provides important information on my professional policies & procedures. Please take a few moments to read over and acknowledge your agreement **by initialing after each one**.

FEES:

My initial diagnostic session is a one-time only charge of $150.00. My standard fee for counseling services is $150.00 for an hour-long individual or family session. For patients who pay privately or have out-of-network benefits, payments are due at the time of your visit. Self-pay patients will be eligible for a 25% prompt-pay discount if services are paid in full at time of visit. If you are sending an adolescent alone to a session, please be sure to send payment with him/her. _____

SESSIONS:

Sessions typically run 50-55 minutes long. I make every effort to conduct my sessions on time, however there are some occasions when the patient before you has an emergency and may need a few more minutes. If you have been waiting for 5 minutes past your appointment time, please speak with the receptionist to determine if there has been a mix-up in communication or if I'm simply running behind schedule. _____

SCHEDULING:

Please call our office at **(913) 338-0400** for any scheduling needs, including to make, change, or cancel an appointment. If you are unable to keep your appointment, please notify our office 24 hours in advance to avoid a fee. If you do not keep your appointment or cancel less than 24 hours before the session, a fee of up to the full standard fee for that session may be charged. _____

CORRESPONDENCE:

Brief phone contact related to your case will be a complimentary part of my service to you, however my time for telephone contact outside of that is fairly limited. Extended phone conversations may result in a moderate charge (for instance, problem-solving by phone will be billed $15.00 per 10-minute segment). Please inform me of any anticipated written correspondence needs in advance. If you need me to update or involve other parties (courts, school personnel, etc.), you will need to sign a release of information before I can contact another person on your behalf. _____

I have read, understand and agree with the above policies.

Signature: _____ **Date:** _____

Lifestyle Insight Therapy, LLC
Sarah Adair, MSW, LCSW, LSCSW

Authorization for Electronic Communication

As a convenience to me, I hereby request that *Lifestyle Insight Therapy, LLC* communicate with me regarding my treatment by Sarah Adair, MSW, LCSW, via electronic communications (e-mail or text message). I understand that this means *Lifestyle Insight Therapy, LLC* and/or my treating providers will transmit my protected health information such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that my protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, *Lifestyle Insight Therapy, LLC* shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by *Lifestyle Insight Therapy, LLC* to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize *Lifestyle Insight Therapy, LLC* to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from *Lifestyle Insight Therapy, LLC* I may revoke this authorization by providing written notice at sadair@kcpsych.com.

I agree that *Lifestyle Insight Therapy, LLC* may communicate with me electronically unless and until I revoke this authorization by submitting notice to *Lifestyle Insight Therapy, LLC* in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize the transmission of my protected health information electronically as described above.

_____

Client Name

_____ _____

Signature of Client Date

Lifestyle Insight Therapy, LLC
Sarah Adair, MSW, LCSW, LSCSW

Patient Registration

Date _____ Clinician _____

Name _____ Social Security # _____
(Last) (First) (MI)

Date of Birth:_____Age:_____ Sex: Male Female

Address _____ City _____ State _____ Zip _____

Email Address_____

Home Phone (_____) _____ Work Phone (_____) _____

Mobile/Alt. Phone (_____) _____

Marital Status: Married Single Partner Divorced Widowed Separated

Name of Employer (or School) _____ Grade _____

Student Status: Full-time _____ Emergency Contact name and ph. #: _____
Part-time_____

RESPONSIBLE PARTY

Responsible Party _____ Relationship to Patient _____
(Last) (First) (MI)

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Business Phone (_____) _____

Social Security # _____ Place of Employment _____

If other family members are seen in this office, please list: _____

***** AT THIS TIME A COPY OF YOUR CURRENT INSURANCE CARD AND PHOTO ID IS REQUESTED *****
ALTHOUGH WE TAKE A COPY OF YOUR INSURANCE CARD, WE DO REQUIRE THE FOLLOWING INFORMATION TO BE COMPLETED.

Primary Insurance Company:

Name: _____

Policy # _____ Group # _____

Subscriber Name: _____

DOB _____ SSN _____

Employer: _____

Secondary Insurance Company:

Name: _____

Policy #: _____ Group #:_____

Subscriber Name: _____

DOB: _____ SSN: _____

Employer: _____

Lifestyle Insight Therapy, LLC
Sarah Adair, MSW, LCSW, LSCSW

My preference for ***automated appointment reminders*** is (please check one):

- ☐ Voice call to Home Telephone Number
- ☐ Voice call to Mobile Telephone Number
- ☐ Text Reminder to Mobile Telephone Number
- ☐ None-I do not wish to get automated reminders

_____

Signature of Patient or Legal Guardian Date

_____

Print Patient Name Print Name of Legal Guardian

Lifestyle Insight Therapy, LLC
Sarah Adair, MSW, LCSW, LSCSW

Consent for Treatment

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to and authorizes services by Sarah Adair. These services may include psychotherapy and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. Be informed of and to participate in the selection of treatment services.
2. Receive a copy of this consent upon request.
3. Withdraw this consent at any time.
4. Be referred to another professional if requested.

_____
Date

_____
Signature of Patient

_____
Signature of Parent, Legal Guardian or Conservator

_____
Signature of Witness

Client Confidentiality

Confidentiality is very important to the therapeutic process, and steps are taken to insure that your records be kept confidential. Please read the following guidelines so that you will understand when information can be released to another party.

Information which might be used to identify a client as a participant in therapy or information form the client's therapy record will not be released without the clients written consent, unless authorized or required by law.

Under certain circumstances it may be required or authorized by law to release information without the client's consent. These include, but are not limited to:

Medical emergencies
Court authorized releases
Clients who represent a serious danger to self or others
Child or elder abuse or neglect

I have read and understand the above information.

_____ _____ _____
Date Client, Parent or Legal Guardian Witness

Lifestyle Insight Therapy, LLC
Sarah Adair, MSW, LCSW, LSCSW

Authorization

I authorize Lifestyle Insight Therapy, Sarah Adair, principle to release any medical information which may be requested to process claims for payment of medical services through an insurance carrier, prepaid medical plan or a government agency. I request that payment be made to my therapist for any bills for service rendered to me by her.

I understand that I am financially responsible to her for any balance not covered by this authorization. I understand that insurance filing is done as a courtesy for the patient and no responsibility is taken by my provider for denial or delay of payment.

_____ _____

Responsible Party's Signature Date

Lifestyle Insight Therapy, LLC

Sarah Adair, LSCSW, LCSW, MSW

Adult History Questionnaire

Please provide the following information. Leave blank any question you would rather not answer, or would prefer to discuss with me. Information you provide here is confidential.

Today's Date:____/____/____ Client Name:_____

Date of Birth:____/____/____ Age:_____ Preferred Name:_____

Preferred Gender:_____ Sexual Orientation:_____

What are the primary concerns that have brought you in today?

_____

_____

_____

_____

_____

Persons living in the household (name/age/relationship):

_____

_____

_____

History

Have you received any type of mental health services in the past (therapy, psychiatric services, etc)?

☐ No ☐ Yes If yes, previous services/practitioner/date:_____

Are you currently receiving additional mental health services (therapy, psychiatric services, etc)?

☐ No ☐ Yes If yes, please describe:_____

Are you currently taking prescribed medication? ☐ No ☐ Yes

If yes, please list/dose:

_____

_____

_____

Family Mental Health History

Have you or your family members experienced any of the following:

☐ Alcohol/Substance Use	☐ Anxiety	☐ Bipolar Disorder
☐ ADHD	☐ Suicide Attempts	☐ OCD
☐ Depression	☐ Eating Disorder	☐ Schizophrenia
☐ Autism Spectrum Disorder	☐ Obesity	☐ Learning Problems

If yes, please list which family member(s):

_____

_____

_____

Current Health

Have you experienced any of the following in the past month?

☐ Increased/Decreased Appetite	☐ Fatigue	☐ Trouble concentrating
☐ Sleep Disturbance	☐ Suicidal thoughts	☐ Impulsive behavior
☐ Acting out/anger	☐ Panic Attacks	☐ Self-harm
☐ Substance Use	☐ Anxiety	☐ Body-Image concerns

☐ Other- Please list:_____

Do you exercise? ☐ No ☐ Yes If yes, how often?_____

Do you drink alcohol? ☐ No ☐ Yes If yes, how many times per week?_____

Do you currently, or in the past, have you used any of the following?

☐ Marijuana	☐ Non-prescribed medication	☐ Cocaine
☐ Heroin	☐ Methamphetamine	☐ Other- Please list:_____

What do you hope to accomplish from our work together?

_____

_____

_____

_____

_____

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

Lifestyle Insight Therapy, LLC
Sarah Adair, MSW, LCSW, LSCSW

NOTICE OF PRIVACY PRACTICES

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

Sarah Adair is committed to protecting your personal health information. If at any time you have any questions or concerns about how your confidential information is being used you are encouraged to notify the practice staff so that appropriate personnel can quickly address and resolve these concerns.

Effective Date: April 13, 2003
This Notice was revised on July 30, 2018.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer:	Jane Freeman
Mailing Address:	8300 College Blvd, Suite 320, Overland Park, KS 66210
Telephone:	(913)338-0400
Fax:	(913)338-0428

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others, but we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

- **Fundraising Activities.** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures of Protected Health Information for marketing purposes; and
3. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization, but disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional chosen by KCPG who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.