Bruce Perham, MSW, LICSW

5100 Dawson St. Suite 103
Seattle, WA 98118
206-973-6152

Intake information (Please complete and bring to the first session.)

Identifying information			
Name:	Date of birth:	Age:	
Address:			
City:	Zip code:		
Were you referred to me by someone:			
Your contact information			
Home Phone:	OK to leave a message Y N		
Cell phone:	OK to leave a message Y N		
Work phone:	OK to leave a message Y N		
Email:			
Financially responsible person __ Self __ Other			
If other: Name:		Relationship:	
Address:		Zip:	
Phone number:	2nd phone:		
Insurance information:			
Primary insurance:		Secondary insurance	
Insured name:		Insured name:	
Ins. DOB:	Ins. SSN:	Insured DOB:	Insured SSN:
Insured Employer:		Insured Employer:	
Health plan:		Health plan:	
Client's relationship to Insured:"		Client's relationship to Insured:"	
___ Self ___Spouse ___Dependent		___ Self ___Spouse ___Dependent	
Member #:		Member #:	
Policy/group:		Policy/group:	
Contact number:		Contact number:	
Emergency contacts:			
Name:		Relationship:	
Phone number:		2nd phone:	

Name:	
Phone number:	2nd phone:
Name:	
Phone number:	2nd phone:
Legal issues: if there are any pending legal issues that might affect our work please briefly explain:	
Employment and Education:	
Employer or school:	
Occupation:	
How long have you been at your current job:	
How satisfied are you in your job not very 1 2 3 4 5 6 7 8 9 10 very satisfied	
Your education:	
Other work experience:	
Previous counseling experience:	
Have you been in counseling in the past? Y N	
If yes, with who?	
When and for how long?	
Purpose?	
Results?	
Medical information:	
How would you describe your overall health? __ Excellent __ Good __ Fair __ Poor	
Primary care physician:	
Major medical issues (chronic illnesses, major injuries etc:	

Do you currently smoke? Y N If yes, packs per days: ____
Have you smoked in the past? Y N
If yes, when did you start? when did you quit?
Do you drink alcohol? Y N
How often? __ Daily __ Several times per week __ Once a week __ 1 – 3 times per month __ Other
Check all that apply: __ Beer __ Wine __ Hard liquor
Do you drugs other than prescription medication?
If yes, which ones?
How often
Have you ever sought help because of your alcohol or drug use? Y N
If yes: __ Inpatient? __ Outptient?
When?
Where?
What was the outcome?
Have you ever been prescribed medication for psychiatric or emotional condition(s)? Y N
If yes, condition:
Medication?
Prescribing provider:
Outcome?
Are you taking other prescription medication?

Medication	Prescribing provider	Purpose	Outcome
1.			
2.			

3.
4.
5.
6.
Social and relationship information:
Relationship status: __ Single __ Partnered __ Married __ Divorced __ Widow(er)
Other:
Gender and ages of children:
Significant friends: How long have you known each other, how do you feel about the friendship?

Life experiences:	
Please check if you have experienced:	Your age at the time:
__ Death of mother	
__ Death of father	
__ Death of a sibling	
__ Death of a child	
__ Divorce of your parents	
__ Desertion by your mother	
__ Desertion by your father	
__ Physical abuse	
__ Emotional abuse	
__ Sexual abuse or rape	
__ Witness domestic violence	

__ Victim of domestic violence	
__ War or related events	
Other significant life events (give description and you age when it occurred)	
Is there a family history of any of the following?	
__ Depression	
__ Anxiety	
__ mental illness	
__ Eating disorder	
__ Suicide or suicide attempt	
__ Physical abuse	
__ Emotional abuse	
__ Sexual abuse	
__ Substance abuse or addiction	
__ Chronic illness	
__ Other	
Recent stressors:	
__ Serious illness or injury - you	
__ Serious illness or injury – family member or close friend	
__ Death of a family member or close friend	
__ New family member	
__ Break up/separation/divorce	
__ Job loss or change	
Other:	
Is there anything else I should know before we start?	

Bruce Perham, LICSW

5100 Dawson St. Suite 103
Seattle, WA 98118
206-973-6152

Informed Consent for Adult Therapy Services

THERAPIST-CLIENT SERVICE AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

THERAPY SERVICES: Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities for both you and me. As a client, you have certain rights and responsibilities that are important for you to understand. There are also legal limits to those rights that you should be aware of. I, as your therapist, also have responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include feeling uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the doing psychotherapy requires talking about the unpleasant parts of your life. However, psychotherapy can have benefits for people who decide to do it. Therapy often leads to feeling less stress, increased satisfaction in relationships, greater awareness and insight, increased skills for managing stress and solutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions. That is why I often “prescribe” homework. If I feel a book or hand-out will benefit you, I will suggest it. Hand-outs I will give you for free, and books or workbooks can usually be found at your local library or through amazon.com for a relatively low cost to you.

The first few sessions will involve a thorough evaluation, or assessment, of many aspects of your past and present life. I will be able to offer you some initial impressions of what our work might involve once I finish your paperwork. You should think about what I tell you and make a decision about whether you feel comfortable working with me. If you have questions about my assessment process, please feel free to ask me. If I can’t answer your question right away, I will get one for you as soon as I can. If you decide at any time that I’m not the right person for you, please let me know and I can help you find someone who you think will be more helpful.

APPOINTMENTS: Appointments will ordinarily be 50 - 55 minutes, once per week, at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to charge the amount I am allowed to bill your insurance company (I will not charge you for your co-pay, too) unless we both agree that you were unable to attend due to

circumstances beyond your control. If it is possible, I will try to find another time during that week to reschedule your appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. Excessive last minute cancellations and re-scheduling, or no-show/no-calls for appointments will be discussed with you and another treatment schedule may need to be worked out. If you miss two appointments in a row due to last minute cancellations or no-shows, your appointment date and time will not be held and you will need to work out another day and/or time with me.

PROFESSIONAL FEES: The standard fee for the initial intake is $150.00 and each session thereafter is $125.00, if you are a privately paying client. Otherwise, your insurance company co-pay rate is expected at each session. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment may be made by check, cash, debit or credit cards. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to obtain payment from you.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for my professional time even if another party compels me to testify.

INSURANCE: In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission and within reason, I will file claims and find out what I can regarding information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide payment for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy or make payment arrangements with you so you can continue therapy with me at a reduced rate.

You should also be aware that most insurance companies require you to authorize that I provide them with a diagnosis. A mental health diagnosis is a term that describes what I think is your problem and whether the problem is a short-term or long-term problem. All diagnoses come from a book entitled the DSM-IV TR. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis. Sometimes I have to provide additional information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some

cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, I may need to get authorization from your insurance company before they will cover therapy fees. If I am not able obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-pay) to be covered by the patient. Either amount is to be paid at the time of the visit by check, cash, debit or credit card. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount, which must be paid by you before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once I have all of the information about your insurance coverage, we will talk about what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your treatment. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my contract with your insurance company.

I would also like you to be aware that when I submit a claim to your insurance company, it can take up to 4-6 weeks before I find out whether I will get paid by them for seeing you or if they deny payment for services I provided to you. If I get a denial, I will do everything I can to help get that denial reversed and have the insurance company pay for my services. If, for some reason, they still refuse to pay the claim, then I will need to make payment arrangements with you for the sessions I already provided to you.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you back to your insurance company to find eligible in-network providers in your area.

PROFESSIONAL RECORDS: I am required to keep records of the services that I provide to you. Your records are maintained in a secure location in my office. I keep brief weekly notes that record the day and time you were here, topics we discussed, and any updated information about your medical, social, and treatment history. Also included in your record may be information I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because your records are professional records, and I use medical terminology, they may be misinterpreted and/or upsetting to you. For this reason, I require that you review them with me. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request (by signing a release of information) and at no cost to you.

CONFIDENTIALITY: My policies about confidentiality, as well as other information about your privacy rights, are fully described in two separate documents on my Forms page, called “HIPAA Rights.” I will review those documents with you in our first session and you will be able to ask me questions about them. Please remember that you can talk to me about them at any time during our work together.

PARENTS & MINORS: While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to teenagers unless s/he agrees that I can share whatever information I consider necessary with their parent(s). I request an agreement between the teen and the parent(s) allowing me to share general information about progress (or lack of progress) and the teen's attendance, as well as a summary upon completion of therapy. All other communication will require the teen's agreement, unless I feel there is a safety concern (see above section on Confidentiality for exceptions), in which case I will make every effort to notify the teen of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING ME: I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, go to your local hospital emergency room or call 911. I will contact you as soon as I possibly can to see what I can do to help you. I would appreciate a phone call from you or one of your loved ones if you do get hospitalized. Also, if I am going to be out, I will attempt to inform you in advance of planned absences, unless I am sick. I will then make every effort to contact you as soon as possible to let you know that I will not be seeing clients that day.

OTHER RIGHTS: If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can talk to you about your concerns. Your feedback will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will never have social or sexual relationships with current or former clients.

CONSENT TO PSYCHOTHERAPY: Your signature below indicates that you have read and that I reviewed this Agreement, the HIPAA Rights with you, and that you agree to these terms.

Signature of Patient or Personal Representative (if applicable)

_____

Signature of Patient or Personal Representative (if applicable)

_____

Bruce Perham, LICSW, witness

Date _____

Bruce Perham, LICSW

5100 Dawson St. Suite 103
Seattle, WA 98118
206-973-6152
bruce@bruceperhamcounseling.com
www.bruceperhamcounseling.com

HIPAA and Washington State Notice of Privacy Practices

NOTICE: I keep record of the health care services I provide you. You may ask me to see and copy that record. You may also ask me to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so. You may see your record or get more information about it at 5100 Dawson St. Suite 103 Seattle, WA 98118

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

Your health record contains personal information about you and your health. State and Federal law protects the confidentiality of this information.

Protected Health Information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical and mental health, or condition, and related healthcare services. If you suspect a violation of these legal protections, you may file a report to the appropriate authorities in accordance with Federal and State regulations.

This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with all applicable law. It also describes your rights regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to your PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will make available a revised Notice of Privacy Practices by sending you an electronic copy, sending a copy to you in the mail upon your request or providing one in person.

How I am permitted to Use and Disclose Your PHI for Treatment.

I may use your protected PHI to provide you with treatment services.

For Payment

I may use and disclose your protected PHI so that I can receive payment for the treatment services provided to you.

For Healthcare Operations.

I may use and disclose your protected PHI for certain purposes in connection with the operation of my professional practice, including supervision and consultation.

Without Your Authorization.

State and Federal law also permits me to disclose information about you without your authorization in a limited number of situations, such as with a court order.

With Authorization.

I must obtain written authorization from you for other uses and disclosures of your PHI. You may revoke such authorizations in writing in accordance with 45 CFR. 164.508(b)(5).

Incidental Use and Disclosure.

I am not required to eliminate every risk of an incidental use or disclosure of your PHI.
Specifically, a use or disclosure of your PHI that occurs as a result of, or incident to an otherwise permitted use or disclosure is permitted as long as I have adopted reasonable safeguards to protect your PHI, and the information being shared was limited to the minimum necessary.

Examples of How I May Use and Disclose Your PHI

Listed below are examples of the uses and disclosures that I may make of your PHI. These examples are not meant to be a complete list of all possible disclosures, rather, they are illustrative of the types of uses and disclosures that may be made.

Treatment.

Your PHI may be used and disclosed by me for the purpose of providing, coordinating, or managing your health care treatment and any related services. This may include coordination or management of your health care with a third party, consultation or supervision activities with other health care providers, or referral to another provider for health care services.

Payment.

I may use your PHI to obtain payment for your health care services. This may include providing information to a third party payor, or, in the case of unpaid fees, submitting your name and amount owed to a collection agency.

Healthcare Operations.

I may use or disclose your PHI in order to support the business activities of my professional practice including; disclosures to others for health care education, or to provide planning, quality assurance, peer review, or administrative, legal, financial, or actuarial services to assist in the delivery of health care, provided I have a written contract with the business that prohibits it from re-disclosing your PHI and requires it to safeguard the privacy of your PHI. I may also contact you to remind you of your appointments.

Other Uses and Disclosures That Do Not Require Your Authorization Required by Law.

I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples of this type of disclosure include healthcare licensure related reports, public health reports, and law enforcement reports. Under the law, I must make certain disclosures of your PHI to you upon your request. In addition, I must make disclosures to the US Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of privacy rules.

Health Oversight.

I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors) and peer review organizations performing utilization and quality control. If I disclose PHI to a health

oversight agency, to the extent I am required by law I will have an agreement in place that requires the agency to safeguard the privacy of your information.

Abuse or Neglect.

I may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect. However, the information we disclose is limited to only that information which is necessary to make the initial mandated report.

Deceased Clients.

I may disclose PHI regarding deceased clients for the purpose of determining the cause of
death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

Research.

I may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the
research and a waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; and (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations.

Criminal Activity or Threats to Personal Safety.

I may disclose your PHI to law enforcement officials if I reasonably believe that the disclosure will avoid or minimize an imminent threat to the health or safety of yourself or any third party.

Compulsory Process.

I may be required to disclose your PHI if a court of competent jurisdiction issues an appropriate order, and if the rule of privilege has been determined not to apply. I may be required to disclose your PHI if I have been notified in writing at least fourteen days in advance of a subpoena or other legal demand, no protective order has been obtained, and a competent judicial officer has determined that the rule of privilege does not apply.

Essential Government Functions.

I may be required to disclose your PHI for certain essential government functions. Such functions include: assuring proper execution of

a military mission, conducting intelligence and national security activities that are authorized by law, providing protective services to the President, making medical suitability determinations for U.S. State Department employees,
protecting the health and safety of inmates or employees in a correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs.

Law Enforcement Purposes.

I may be authorized to disclose your PHI to law enforcement officials for law enforcement purposes under the following six circumstances, and subject to specified conditions: (1) as
required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) in response to a law enforcement official's request for information about a victim or suspected victim of a crime; (4) to alert law enforcement of a person's death, if I suspect that
criminal activity caused the death; (5) when I believe that protected health information is evidence of a crime that occurred on my premises; and (6) in a medical emergency not occurring on my premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.

Psychotherapy Notes.

I must obtain your authorization to use or disclose psychotherapy notes with the following exceptions. I may use the notes for your treatment. I may also use or disclose,
without your authorization, the psychotherapy notes for my own training, to defend myself in legal or administrative proceedings initiated by you, as required by the Washington Department of Health or the US Department of Health and Human Services to investigate or determine my compliance with applicable regulations, to avert a serious and imminent threat to public health or safety, to a health oversight agency for lawful oversight, for the lawful activities of a coroner or medical examiner or as otherwise required by law.

Uses and Disclosures of PHI With Your Written Authorization.

Other uses and disclosures of your PHI will be made only with your written authorization. I will not make any other uses or disclosures of your psychotherapy notes, I will not use or disclosure your PHI for marketing proposes, and I will not sell your PHI without your authorization. You may revoke your authorization in writing at any time. Such revocation of

authorization will not
be effective for actions I may have taken in reliance on your authorization of the use or disclosure.

Your Rights Regarding Your PHI.

You have the following rights regarding PHI that I maintain about you. Any requests with respect to these rights must be in writing. A brief description of how you may exercise these rights is included.

Right of Access to Inspect and Copy.

You may inspect and obtain a copy of your PHI that is contained in a designated record set for as long as I maintain the record. A "designated record set" contains medical and billing records and any other records that I use for making decisions about you. Your request must be in writing. I may charge you a reasonable cost-based fee for the copying and transmitting of your
PHI. I can deny you access to your PHI in certain circumstances. In some of those cases, you will have a right of recourse to the denial of access. Please contact me if you have questions about access to your medical record.

Right to Amend.

You may request, in writing, that I amend your PHI that has been included in a designated record set. In certain cases, I may deny your request for an amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with me. I 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 may request an accounting of disclosures other than those made to you, for treatment purposes, or made as a result of your authorization, for a period of up to six years. I may charge you a reasonable fee if you request more than one accounting in any 12-month
period. Please contact me if you have questions about accounting of disclosures.

Right to Request Restrictions.

You have the right to ask me not to use or disclose any part of your PHI for treatment, payment or health care operations or to family members involved in your care. Your request for
restrictions must be in writing and I am not required to agree to such restrictions. You also have the right to restrict certain disclosures of

your PHI to your health plan if you pay out of pocket in full for the health care I provide to you. Please contact me if you would like to request restrictions on the disclosure of your PHI.

Right to Request Confidential Communication.

You have the right to request to receive confidential communications from me by alternative means or at an alternative location. I will accommodate reasonable written requests. I may also condition this accommodation by asking you for information regarding how payment will be handled or specification of an alternative address or other method of contact. Please contact me if you would like to make this request.

R**ight to a Copy of this Notice**.

You have the right to obtain a copy of this notice from me. Any questions you have about the contents of this document should be directed to me.

Right to opt out.

You have the right to choose not to receive fundraising communications. However, I will not contact you for fundraising purposes.

Right to Notice of Breach.

You have the right to be notified of any breach of your unsecured PHI.

Contact Information

I act as my own Privacy and Security Officer. If you have any questions about this Notice of Privacy Practices, please contact me. My contact information is:

Bruce Perham, MSW, LICSW
5100 Dawson St. Suite 103
Seattle, WA 98118

Complaints

If you believe I have violated your privacy rights, you may file a complaint in writing with me, as my own Privacy Officer, as specified above. You also have the right to file a complaint in writing to the Washington Department of Health or to the US Secretary of Health and Human Services. I will not retaliate against you in any way for filing a complaint.

Effective Date

Effective date of this notice: October 12, 2013

I have received, read, and fully understand the HIPAA Rights disclosures set forth above.

_____
Print Name

_____ _____
Client Signature Date