My Mindful Way of Life

In order to save you time when you come for your first appointment, we have devised this thorough questionnaire for you to fill out prior to your visit. We estimate that it will take approximately 45 minutes to complete all of the forms. Understanding your unique situation helps us to treat you more effectively. Thank you for taking the time to assist us with this.

This packet contains:

• An Adult Information Form - This form asks you for background information that is pertinent for us to understand to provide you with the most integrative services. Although the form looks long, it is mostly in a checklist/ circle-yes-or-no format, so it should be fairly simple to complete. Please let us know if you have any questions.

• A Notice of My Mindful Way of Life's Policies and Practices to Protect the Privacy of Your Health Information form - This form is provided for your information, so you will know how we protect your private information and respect your rights to privacy.

• A Statement of Understanding - This is a 1-page form for you to sign indicating that you understand and agree to our privacy policies and financial policies.

• A Clinical Communication Form - This is a 1-page form asking permission for Dr. Klich to contact your physician or other clinician regarding your treatment at My Mindful Way of Life.

Contact Information

Name_____ Date of Birth_____ Age_____ Sex M or F
Address_____
City_____ State_____ Zip_____ Home Phone_____
Work Phone_____ Cell Phone _____ Email _____
Person responsible for bill_____ Relationship to client_____

Communication Preference

In the event we need to contact you to change an appointment or otherwise communicate, please indicate your preference below.

(Check one)

☐ Please call _____ May we leave a general message at this number YES☐ NO☐
(phone number) (date)

☐ Please EMAIL a general messages me at _____

Signature: _____ Date: _____

Please note that you may change your preference at anytime and we request you do so in writing. Thank you.

The following information will help your therapist to better understand you and your needs. This, as well as other communications with your therapist, will be kept confidential to the full extent of Georgia law.

Were you referred for consultation by another professional? Yes or No (circle one)
If yes, referral source_____
If you would like for your therapist to contact your referring professional to coordinate treatment, you will need to fill out a "Release of Information" form to give permission.

Current concerns
What brought you to counseling? *(What behaviors, feelings, thoughts, or problems are causing you distress or creating difficulties in your life?)*

_____
_____
What are your goals in coming here? *(What kinds of changes do you want to make, or how do you want things to be different for you and/or your family?)*

_____
_____

Demographics

☐ Single ☐ Living together
☐ Married/Domestic Partner ☐ Separated
☐ Divorced ☐ Widowed

If you are married/ partnered, for how long? _____ Previous marriages?_____
Please list your spouse and children (if applicable), and any others who may be living with you:

Name_____ Age____ Relationship_____ Living with you? Yes or No

Name_____ Age____ Relationship_____ Living with you? Yes or No

Name_____ Age____ Relationship_____ Living with you? Yes or No

Name_____ Age____ Relationship_____ Living with you? Yes or No

Name_____ Age____ Relationship_____ Living with you? Yes or No

Name_____ Age____ Relationship_____ Living with you? Yes or No

Name_____ Age____ Relationship_____ Living with you? Yes or No

Please let us know if there is a relationship that you are currently having difficulty with.

_____

Problem areas
Please place a check next to each problem or symptom that is currently a concern for you:

- ☐ Anxiety/ worry
- ☐ Fearfulness/ phobias/ panic attacks
- ☐ Concerns about weight or eating
- ☐ Emotional sensitivity
- ☐ Difficulty adjusting to a life change
- ☐ Strange thoughts or experiences
- ☐ Feeling disconnected/ numb
- ☐ Difficulty concentrating
- ☐ Sleep problems
- ☐ Low energy, difficulty getting things done
- ☐ Irritability
- ☐ Feeling unhappy a lot of the time
- ☐ Self-harming behaviors
- ☐ Employment or work problems
- ☐ Marital or relationship problems
- ☐ Stress from caring for a family member
- ☐ Insecure/ timid/ lack of self-confidence
- ☐ Discomfort in social situations
- ☐ Friendship problems
- ☐ Stress from physical or health concerns
- ☐ Problems related to alcohol or other drug use
- ☐ Problems related to spending money
- ☐ Legal problems
- ☐ Unsafe or risky behavior
- ☐ Concern about a family member
- ☐ Obsessive thoughts or compulsive behavior
- ☐ Frequent nightmares/ intense bad memories
- ☐ Anger/ difficulty controlling temper
- ☐ Can't move on or forgive someone
- ☐ Feeling out of control
- ☐ Forgetfulness
- ☐ Frequently tense or unable to relax
- ☐ Grief from the loss of an important person
- ☐ Feeling overwhelmed or hopeless
- ☐ Guilt or regrets
- ☐ Thoughts of suicide
- ☐ Academic problems or educational concerns
- ☐ Financial problems
- ☐ Stress from problems with children
- ☐ Stress from other problems in the family
- ☐ Low self-esteem
- ☐ Loneliness
- ☐ Religious or spiritual concerns
- ☐ Sexual or intimate concerns
- ☐ Problems related to gambling
- ☐ Spending too much time on computer
- ☐ Traumatic stress
- ☐ Other _____

Which areas of your life are satisfying or going well right now?

- ☐ Family life
- ☐ School
- ☐ Social life
- ☐ Physical health
- ☐ Other_____
- ☐ Work
- ☐ Spiritual life
- ☐ Hobbies/ recreation
- ☐ Financial situation

Recent changes or stressful circumstances (Circle one)

1. Have there been any recent deaths in the family? Yes or No
2. Has there been a significant change in your primary relationship (marriage, separation, divorce, infidelity etc.)? Yes or No
3. Have any new children been adopted or born or come to live with the family? Yes or No
4. Have you experienced the loss or termination of a pregnancy? Yes or No
5. Have you had stress from child custody concerns or arguments with an ex-spouse? Yes or No
6. Have you had stress from difficulties with in-laws or extended family? Yes or No
7. Have you recently moved? Yes or No
8. Have you been separated from your spouse or partner for a long period of time (because of deployment, incarceration, work relocation, etc.)? Yes or No
9. Has your child recently left home? Yes or No
10. Have you had a disruption in an important friendship or other relationship? Yes or No
11. Have you had a change in your religious or spiritual community or affiliation? Yes or No
12. Have you experienced unusual stress from a child's problems or difficulties? Yes or No

13. Have you or a family member been seriously ill or hospitalized? Yes or No
14. Have you had lifestyle changes because of a recently diagnosed or chronic illness? Yes or No
15. Have you or a close family member had recent legal problems or been in prison? Yes or No
16. Has a family member had emotional, mental health, or substance abuse problems? Yes or No
17. Have you been under stress from too many activities or responsibilities? Yes or No
18. Have there been a lot of arguments or conflicts at home? Yes or No
19. Have you recently started an academic program or dropped out or graduated? Yes or No
20. Have you had a change in employment (job change, job loss, promotion, retirement)? Yes or No
21. Have you had a highly stressful work environment or problems at work? Yes or No
22. Have you recently had a change in financial status or financial stress? Yes or No
23. Have you been in financial difficulty or had inadequate income, inadequate health care, inadequate or unsafe living situations, or frequent worry about these? Yes or No
24. Have you witnessed verbal, emotional, physical or sexual abuse; threatening or disturbing behavior; or a scary situation (such as a car accident or crime)? Yes or No
25. Have you personally experienced verbal threats, threatening behavior, physical violence, sexual assault or a scary situation (such as a car accident or crime)? Yes or No

If you answered "Yes" to any of the questions about stressful circumstances, please explain briefly:

_____

_____

What sources of support do you have in your life right now?_____

_____

How do you typically respond to problems or stress? (check all that apply)

- ☐ Sleep a lot
- ☐ Get moody or sensitive
- ☐ Lose patience more
- ☐ Have physical symptoms
- ☐ Avoid thinking about it
- ☐ Increase computer time
- ☐ Ask for help
- ☐ Try to solve the problem
- ☐ Ask your spouse/partner or friend for comfort
- ☐ Re-focus on spiritual beliefs and activities
- ☐ Give up or give in
- ☐ Withdraw
- ☐ Eat more/ less than usual
- ☐ Focus on a hobby/activity
- ☐ Frequently tell others about your situation
- ☐ Need to be with others constantly
- ☐ Have trouble sleeping
- ☐ Discuss it with a spouse/partner or friend
- ☐ Focus on caring for others
- ☐ Get bossy or controlling
- ☐ Watch a lot of TV
- ☐ Fight with family/friends
- ☐ Ignore the problem
- ☐ Blame others
- ☐ Use alcohol or other drugs
- ☐ Vent anger/blow off steam
- ☐ Exercise more
- ☐ Take it out on others
- ☐ Pray
- ☐ Cry a lot
- ☐ Stay busy/ work more

Health History

Please tell us about any previous mental health treatment you have received from a counselor, psychologist, psychiatrist, or your doctor (including therapy or psychiatric medication)

If yes, please list:

Name of treatment provider	Location	Phone number	When?

Please list your current health problems or chronic medical diagnoses:

Health Problem/ Condition	How does this condition affect you?	Who is treating you?

Please list your current medications, including supplements or herbal medicines:

Name of medication	Dosage	When start taking it?	What is the medication for?	Who prescribes it?

Did you have any difficulty with developmental delay as a child (such as problems with walking, eating, communicating or caring for yourself)? Yes or No

Do you have any history of serious illness, injury, concussions, car accidents, hospitalizations or operations? Yes or No

Do you experience chronic or recurrent pain? Yes or No

Do you have any problems with vision or hearing? Yes or No

Do you have any problems with balance or coordination? Yes or No

Have you received any previous neurological evaluations, medical imaging, neuropsychological assessments or psychological evaluations? Yes or No

If yes to any of the above, please describe:_____

_____

_____

Which best describes your experience with..

Cigarettes	☐ Do not use	☐ Used but quit	☐ Use occasionally	☐ Use weekly	☐ Use daily
Other forms of tobacco	☐ Do not use	☐ Used but quit	☐ Use occasionally	☐ Use weekly	☐ Use daily
Caffeine	☐ Do not use	☐ Used but quit	☐ Use occasionally	☐ Use weekly	☐ Use daily
Alcohol	☐ Do not use	☐ Used but quit	☐ Use occasionally	☐ Use weekly	☐ Use daily
Non-prescribed painkillers	☐ Do not use	☐ Used but quit	☐ Use occasionally	☐ Use weekly	☐ Use daily
Prescribed painkillers	☐ Do not use	☐ Used but quit	☐ Use occasionally	☐ Use weekly	☐ Use daily
Narcotics	☐ Do not use	☐ Used but quit	☐ Use occasionally	☐ Use weekly	☐ Use daily
Steroids	☐ Do not use	☐ Used but quit	☐ Use occasionally	☐ Use weekly	☐ Use daily
Marijuana	☐ Do not use	☐ Used but quit	☐ Use occasionally	☐ Use weekly	☐ Use daily
Stimulants	☐ Do not use	☐ Used but quit	☐ Use occasionally	☐ Use weekly	☐ Use daily
Methamphetamine	☐ Do not use	☐ Used but quit	☐ Use occasionally	☐ Use weekly	☐ Use daily
Cocaine	☐ Do not use	☐ Used but quit	☐ Use occasionally	☐ Use weekly	☐ Use daily
Heroin	☐ Do not use	☐ Used but quit	☐ Use occasionally	☐ Use weekly	☐ Use daily
Hallucinogens	☐ Do not use	☐ Used but quit	☐ Use occasionally	☐ Use weekly	☐ Use daily
Other recreational drugs	☐ Do not use	☐ Used but quit	☐ Use occasionally	☐ Use weekly	☐ Use daily

Have you, a family member or a friend felt or expressed concern regarding: (check all that apply)

☐ Your behavior or decision-making when using alcohol or drugs
☐ The effect of your alcohol or drug use on your relationships
☐ The effect of your alcohol or drug use on your work or productivity
☐ The amount of money you were spending on alcohol or drugs
☐ The effect of your alcohol or drug use on your health
☐ The impact of your alcohol or drug use on your work performance or other activities
☐ Safety or legal risks related to your alcohol or drug use
☐ The use of alcohol or drugs as a coping mechanism to deal with stress
☐ None of the above

How much sleep do you typically get each night? _____ hours

What best describes your sleep? (check all that apply):

☐ Have no sleep problems
☐ Don't get enough sleep
☐ Wake too early
☐ Have irregular sleep patterns
☐ Wake up refreshed in the morning
☐ Sleep too much
☐ Have problems falling asleep
☐ Wake frequently at night
☐ Have frequent nightmares
☐ Hard to wake up in the morning

What best describes your energy level and exercise habits? (check all that apply)

☐ Have a low energy level
☐ Have a high energy level
☐ Occasionally exercise
☐ Exercise daily
☐ Need a lot of vigorous exercise to relax or sleep well
☐ Have a normal energy level
☐ Rarely exercise
☐ Exercise a few times a week
☐ Exercise intensely (more than most people)

Who in your family has a history of: (CIRCLE all that apply)

Depression	mother	father	sibling	mother's relative	father's relative
Bipolar disorder	mother	father	sibling	mother's relative	father's relative
Anxiety disorder	mother	father	sibling	mother's relative	father's relative
Obsessive-compulsive	mother	father	sibling	mother's relative	father's relative
Phobias	mother	father	sibling	mother's relative	father's relative
Psychotic disorder	mother	father	sibling	mother's relative	father's relative
Autism or Asperger's	mother	father	sibling	mother's relative	father's relative
Attention disorder	mother	father	sibling	mother's relative	father's relative
Learning disorder	mother	father	sibling	mother's relative	father's relative
Intellectual disorder	mother	father	sibling	mother's relative	father's relative
Substance abuse	mother	father	sibling	mother's relative	father's relative
Gambling/ sexual addiction	mother	father	sibling	mother's relative	father's relative
Anger control problems	mother	father	sibling	mother's relative	father's relative
Eating disorder	mother	father	sibling	mother's relative	father's relative
Personality disorder	mother	father	sibling	mother's relative	father's relative
Emotional problems	mother	father	sibling	mother's relative	father's relative

Employment and Educational History

Which best describe your current employment status (check all that apply):

- ☐ Caring for family full-time
- ☐ Employed outside the house part-time
- ☐ Retired
- ☐ Unemployed/ seeking employment
- ☐ Generally satisfied with employment
- ☐ Active duty military
- ☐ Military veteran
- ☐ Irregular hours
- ☐ Work too many hours each week
- ☐ Contract work/ uncertain income
- ☐ Employed outside the house full-time
- ☐ Self-employed
- ☐ Volunteer work
- ☐ Underemployed
- ☐ Dissatisfied with employment situation
- ☐ Military reserve
- ☐ Long commute to work
- ☐ Work evening or night shift
- ☐ Stressed from juggling work and family
- ☐ Making a career transition

What is your current occupation?_____

What is your highest educational attainment?

- ☐ Some high school
- ☐ Some college
- ☐ Bachelor's degree
- ☐ GED
- ☐ Technical degree/ diploma
- ☐ Master's degree
- ☐ High school diploma
- ☐ Associate's degree
- ☐ Doctoral degree

In school, did you ever have: (check all that apply)

- ☐ Academic or learning problems
- ☐ Problems completing homework or assignments
- ☐ Problems adjusting to school, classroom routines or teacher(s)
- ☐ Problems managing schedule and responsibilities
- ☐ Social difficulties

Please describe any difficulties_____

_____

Social History

Which best describe your usual temperament or personality? (check all that apply)

- ☐ Cheerful
- ☐ Moody
- ☐ Optimistic
- ☐ Efficient
- ☐ Driven
- ☐ Busy, energetic
- ☐ Extroverted (prefer socializing)
- ☐ Adaptable
- ☐ Self-confident
- ☐ Cautious in new situations
- ☐ Prefer a regular routine
- ☐ Eager or enthusiastic in new situations
- ☐ Able to tolerate lots of stimulation
- ☐ Easy-going, laid back
- ☐ Quiet
- ☐ Disorganized
- ☐ Persistent, determined
- ☐ Fun-loving
- ☐ Calm, low-key
- ☐ Introverted (prefer "alone time")
- ☐ Emotional or intense
- ☐ Analytical and careful
- ☐ Prefer variety and change
- ☐ Generally even-tempered
- ☐ Dedicated
- ☐ Sensitive to noise, lights, stimulation
- ☐ Frequently irritable
- ☐ Loud
- ☐ Flexible
- ☐ Easily distracted
- ☐ Focused
- ☐ Spontaneous
- ☐ Shy
- ☐ Stable
- ☐ Dramatic
- ☐ Overwhelmed
- ☐ Loyal
- ☐ A leader

Which best describe your relationships with others? (check all that apply – you may comment below to explain further if you would like)

- ☐ I have a wide circle of friends and contacts
- ☐ I am close with my family of origin
- ☐ My relationships are supportive to me
- ☐ I am generally satisfied with my family life
- ☐ No one knows me well
- ☐ People tell me I'm too controlling
- ☐ I feel alone even when I am with others
- ☐ I feel that I often disappoint others
- ☐ Often people want/need too much from me,
- ☐ I feel uncomfortable when I am by myself
- ☐ I often end up in leadership positions
- ☐ Other people say I am cold or insensitive
- ☐ My relationships are friendly but not close
- ☐ Often people want/need too much from me
- ☐ I have one or more close friends
- ☐ I have a hard time trusting others
- ☐ I have a hard time getting along with people
- ☐ Often I am let down by people I know
- ☐ I have a hard time standing up for myself
- ☐ I have people I can count on if needed
- ☐ I have people who accept me just as I am
- ☐ I am not very interested in relationships
- ☐ Often people want/need too much from me
- ☐ I think I am too sensitive in relationships
- ☐ I have problems with people in authority
- ☐ I have a hard time getting along with people
- ☐ Even though I am interested in relationships, I can't seem to find people to connect with

Comments:_____

_____

_____

Do you attend a church, mosque, synagogue, temple or other spiritual or religious center? What role does spirituality or religion play in your life?

_____

_____

With what groups or organizations are you involved? What are your hobbies and leisure activities?

_____

_____

Thank you for taking the time to provide this important information. If there is any additional information that you would like me to know prior to your visit, please make a note below or let me know you would like me to ask about it. We will of course be discussing the reason for your visit at your initial meeting. I look forward to meeting with you.

_____

_____

_____

My Mindful Way of Life, LLC. Statement of Understanding

Financial Responsibility
Payment is due at the time of the visit. You maintain full responsibility for paying all charges for services rendered at the time of the visit. Dr. Klich will provide a bill with a diagnosis code should you wish to submit to insurance. This is a personal decision which we are happy to discuss with you. Nevertheless, payment must be made at the time services are rendered. Dr. Klich at My Mindful Way of Life, LLC. accepts payment by cash, or credit card including Visa, MasterCard, Discover, American express and apple pay.

Dr. Klich reserves the right to charge the session rate of $200 for all services rendered on your behalf, including, but not limited to, phone conversations, insurance form completion, correspondence, etc. except when agreed upon by you and Dr. Klich. Fees for LEGAL SERVICES are charged at a different rate from clinical services. Please ask for a fee schedule for nonclinical services. Such services include, but is not limited to, court appearances, travel, depositions, attorney correspondence/communication, affidavits, etc.

Cancellation Policy
In the event of an emergency, you will not be charged for session cancellation as a one-time courtesy. We reserve the right to ask for proof of emergency. Cancellations for any other reasons that are not received by center staff at least 48 hours prior to the scheduled sessions will be billed at the usual session rate of $200.00. Monday appointments must be cancelled by noon on the preceding Thursday, and appointments scheduled on the day after a holiday must be cancelled on the business day prior to the holiday. **Please note if you are submitting to insurance your insurance company will not pay for missed appointments.

Protected Health Information
Your therapist may be required by your insurance company to disclose your protected health information (PHI), and some insurance companies require coordination of care with your Primary Care Provider (PCP).

Effective Date, Restrictions, and Changes to Privacy Policy
We reserve the right to modify the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. In the event of a modification, we will provide you with a revised notice by mail or during your next session.

Informed Consent
By affixing my signature to this form, I acknowledge that I have read, understood, and agreed to all of the policies detailed above. I have read My Mindful Way of Life''s Policies and Practices to Protect the Privacy of Your Health Information, and / both understand and approve of its content. I consent for my therapist to disclose PHI to my insurance company or PCP if required for payment of claims.

_____	_____
Printed Name of Client	Witness
_____	_____
Signature of Client and/or Guardian	Date

Notice of My Mindful Way of Life Center's Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

• "PHI" refers to information in your health record that could identify you.

• "Treatment, Payment and Health Care Operations" —

- *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example treatment would be when we consult with another health care provider, such as your family physician or another Therapist. Another example would be when we release your treatment plan to your insurance company and/or to your primary care physician.
- *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

• "Use" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

• "Disclosure" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes we have made about your conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

• Child Abuse — If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority.

• Adult and Domestic Abuse —If we have reasonable cause to believe that a disabled adult or elderly person has had a physical injury or injuries inflicted upon such disabled adult or elderly person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authority.

• Health Oversight Activities — If we are the subject of an inquiry by the Georgia Board of Psychological Examiners, we may be required to disclose protected health information regarding you in proceedings before the Board.

• Judicial and Administrative Proceedings —If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof', such information is privileged under state law, and we will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance it this is the case.

• Serious Threat to Health or Safety — If we determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger you or the intended victim.

• Worker's Compensation — we may disclose protected health information regarding you authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault. Whenever possible we have you sign a permission to release information.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

• Right to Request Restrictions — You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.

• Right to Receive Confidential Communications by Alternative Means and at Alternative Locations — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing therapists. On your request, we will send your bills to another address.)

• Right to Inspect and Copy — You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may

have this decision reviewed. On your request, we will discuss with you the details of the request and denial process. Your therapist may also deny access to your Psychotherapy Notes.

• Right to Amend — You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

• Right to an Accounting — You generally have the right to receive and accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.

• Right to a Paper Copy — You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

If we revise these policies and procedures, we will notify you by mail or on your next session.

V. Complaints

If you are concerned that your therapist have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Dr. Klich. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Dr. Klich can provide you with the appropriate address upon request.

VI. Cancellation Policy

Dr. Klich reserves the right to charge her session rate of $200 for all services rendered on your behalf, including, but not limited to, phone conversations, insurance form completion, correspondence, etc except when agreed upon by you and Dr. Klich. Fees for LEGAL SERVICES are charged at a different rate from clinical services. Please ask for a fee schedule for nonclinical services. Such services include, but is not limited to, court appearances, travel, depositions, attorney correspondence/communication, affidavits, etc.