



P.O. Box 339
Ashton, MD 20861
800.491.5369 • Fax: 301-774-3678

Office Use Only – Counselors please complete before submitting new Intakes.

Paypal ID _____ Initial Interview Date _____
Location _____ Association _____
Counselor _____ Fee/Insurance _____

INTAKE FORM

Please print and give complete information

Client Name _____ Male/Female _____ Race _____

Date of Birth _____ Current Age _____ Social Security Number _____

Parent(s)/Guardian (if under 18 years of age) _____

Street Address _____

City _____ State _____ Zip Code _____

County of Residence _____

Home Telephone _____ Work Telephone _____ Other (specify) _____

May a telephone message be left for you at these numbers? Yes No _____

Please indicate any restrictions for leaving messages _____

Current Marital Status:

Single Engaged Married Remarried Separated Divorced Widowed Living w/Significant Other

Spouse's Name: _____

Would you like to receive our newsletter via email? Yes No Email Address: _____

People Living in the Home - Male	Age	People Living in the Home - Female	Age

Spiritual: Religious Denomination/Affiliation _____ Church Attending _____

Referral: How did you learn about CentrePointe? Clergy Family Friend CP Website/Online Search

Physician Other (BCMD/Church/CP Counselor/Insurance/Phonebook) _____

Name of referring person/agency/church _____

Education: (circle highest grade completed) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 20+

Degree/Major _____ School (if currently a student) _____

Insurance: I will use insurance Yes No Policy Number: _____

Company _____ Claims Telephone Number _____

Type of plan PPO HMO POS Policy Holder _____

(note: if client is a minor, please complete the following employment information for parents'/guardians' employment)

Employer/Company _____ Job Title _____ Gross Salary _____

Street Address _____ City _____ State _____ Zip Code _____

Spouse's Employer _____ Job Title _____ Gross Salary _____

Street Address _____ City _____ State _____ Zip Code _____

Medical and Mental Health Information

Primary Physician _____ Telephone _____
 Street Address _____ City _____ State _____ Zip Code _____

Please list any current medical conditions and treatments (including prescription, over-the counter, herbal, etc.)

Medical Condition/Concern	Medication/Treatment	Dosage/Frequency

Are you currently seeing a psychiatrist, psychologist, or other counselor/therapist? Yes No

Name _____ Telephone _____
 Street Address _____ City _____ State _____ Zip Code _____

Have you ever received psychological services before? Yes No

When? From/To	Clinician/Therapist/Agency	Reason for Treatment	Results

Have you ever taken medications for emotional or psychological problems? Yes No

When?	Prescribing Physician	What Medication?	For What?	Results

Please indicate the frequency and amount that you currently consume:

	How much?	How often?			
			Recent Increase	Recent Decrease	Past Use
Caffeine					
Alcohol					
Tobacco					
Marijuana					
Pornography					

What is happening in your life that resulted in this appointment? Briefly summarize issues you wish to discuss.



Professional Disclosure Statement & Consent for Treatment

Counselor Professional Education & Certifications

Details are listed on the agency website www.centrepointecounseling.org and on business cards. Licenses for staff are displayed in counseling offices when possible and are on file in the central office.

Fees

The professional counseling fee for individuals, families, and couples is \$125 per 45-minute session, **except for the first session which is \$155**. The professional counseling fee for group therapy is \$60 per 90-minute session. Fee

Payment

Clients are expected to make payment at the beginning of each session—including the initial session. Please make **checks payable to CentrePointe**. There is a **\$10** service charge for returned checks. When insurance is used, copayments are expected at the time of service and clients are responsible for any unreimbursed portion of the fee as contractually allowed. Credit card payments can be made at www.centrepointecounseling.org by clicking on “make a payment.” Payment should be made online before the therapy session occurs.

Cancellation Policy

Your counselor has reserved time specifically for you for each session. Therefore, it is necessary to charge your established fee for sessions that are not canceled **at least 24 hours in advance of your appointment. To cancel appointments**, please call your counselor at 800.491.5369 and leave a message on the 24-hour answering machine. Per federal law, Medicaid clients are not charged. For all clients, frequent absences may result in discharge because therapy cannot be effectively provided with inconsistent attendance.

This information is required by the Board of Social Work Examiners & the Board of Examiners of Professional Counselors which regulate all licensed clinical social workers & professional counselors. The Board addresses and phone numbers are:

Maryland Social Work Board of Examiners, 4201 Patterson Avenue, Baltimore, MD 21215-2299, 410-764-4788.

Maryland State Board of Examiners of Professional Counselors and Marriage and Family Therapists, 4201 Patterson Avenue, Baltimore, MD 21215-2299, 410-764-4732.

Virginia Board of Counseling, 9960 Maryland Drive, Suite 300, Henrico, VA 23233-1463, 804-367-4610.

Virginia Board of Social Work, 9960 Maryland Drive, Suite 300, Henrico, VA 23233-1463, 804-367-4441.

Counseling

Counseling is a confidential relationship between you and your counselor. Your counselor promises to have been trained as a professional, to reserve a specific time for you each week or as arranged, to plan for each session, to actively listen, and to give constructive feedback.

You are asked to attend each session, to spend the time between sessions reflecting upon or trying out that which emerged in each session, and to talk in each session about the issues and experiences which are bothering you.

Office Policies and Procedures

Confidentiality

You are entitled to confidentiality in the counseling relationship. However, this is limited by law. All mental health professionals are required by law to suspend confidentiality if there is a clear indication that a client may injure self or others. Mental health professionals must also report any physical/sexual abuse and/or neglect of any person under 18 years of age, the elderly, or impaired. If other confidential information is requested for release, you will be asked to sign a release of information form.

Prescription Drugs

You agree to inform your counselor if you are taking any medication(s), prescription or other, and the dosage. If you are taking medication prescribed by a physician, you agree to take the recommended dosage as prescribed. If there is a problem with any prescribed medication or dosage, you are to return to your physician immediately for assessment.

Alcohol and Substance Use and Abuse

If one of your issues is substance abuse, you are to remain alcohol and drug free. You must not come to a session while intoxicated. Doing so will cause the session to be terminated with full fee payable.

Emergencies or Crises

If you are experiencing an emergency or crisis, you are directed to call 911 or go to your nearest emergency room. You may then request the hospital staff to contact your counselor.

Court Appearance Requests

Counselors do not appear in court unless ordered to testify by a judge.

Phone Calls to Your Counselor

For telephone or other than a brief check-in, an over-the-phone session may be arranged—usually during normal office hours and will be charged at the regular rate. Please do not contact the church or association office where you come for therapy. Staff members at the churches do not work for CentrePointe, and it is a confidentiality violation for them to become involved.

Electronic Communication and Consent for Use

Be advised that the use of email, cell phone texting, and other forms of technology in counseling and psychotherapy may have security concerns. Any information exchanged electronically or with the use of technology increases the risk of confidentiality breaches. Communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. Therefore, the therapist cannot guarantee protection from unauthorized attempts to access, use, or disclose personal information exchanged electronically. Do not include personal identifying information such as your birth date, or personal medical information in any emails you send.

No one can diagnose your condition from email or other written communications, and communication via electronic formats cannot replace the relationship the client has with their therapist. **Be advised that CentrePointe Counseling Inc. does not provide crisis**

intervention, and email/cell phone texting is not a reliable way of obtaining urgent help from the therapist in an emergency.

Electronic communication with me (the Client) can, at the discretion of the therapist, be used for the purpose of simplifying and expediting scheduling/administrative matters only. I am aware that any electronic communication the therapist receives from me and any responses the therapist sends to me may become a part of your legal medical record.

Electronic communication is NOT to be used to provide/receive treatment services or take the place of therapy sessions. Therefore, email/texting should NOT be used to communicate: Suicidal or homicidal thoughts or plans, urgent or emergency issues, serious or severe side effects or concerns, or rapidly worsening symptoms. In a life-threatening emergency client should: Call 911, proceed to the nearest hospital emergency room, and/or call a crisis hotline such as 512-472-HELP or 1-800-SUICIDE.

I have thoroughly considered all the above information. By signing this document, I consent to the use of email as needed for scheduling and administrative purposes only, within the guidelines above, understanding that my therapist may not see e-mails/texts and understanding that my therapist may not respond at all to any text or e-mail. If more urgent help is needed, I will use the crisis services listed above. Furthermore, if at any time my therapist or I believe email/texting is interfering in my therapeutic process or being used ineffectively, either of us can revoke this consent verbally, refuse to respond to emails/texts, and insist upon a verbal conversation before proceeding.

Professional Disclosure Statement for Video-based Counseling

The following information is to be completed by the person being served or the person's authorized representative/parent.

The purpose of this section is to inform you, the client, about many aspects of video counseling services: the process, the counseling, the potential risks and benefits of services, potential failures and shortcomings in existing technology, safeguards against those risks, and alternatives to online services. Please read this entire section before signing.

A. Process

1) Possible misunderstandings: The client should be aware that misunderstandings are possible with video chat software, misunderstandings may occur due to connection problems causing image delays or less than optimal image quality. Counselors are observers of human behavior and gather much information from body language, vocal inflection, eye contact, and other non-verbal cues. If you have never engaged in video counseling before, please have patience with the process and clarify information if you think your counselor has not understood you well. Also, please be patient if your counselor asks for periodic clarification.

2) Privacy: Although the internet provides the appearance of anonymity and privacy in counseling, privacy is more of an issue online than in person. CentrePointe has chosen to use either Zoom via Ring Central as the software provider for web conferencing, and chat

communications between the counselor and clients. The client is responsible for securing his or her own computer hardware, internet access points, and password security. Recording video counseling session is prohibited.

B. Potential benefits: The potential benefits of receiving mental health services online include both the circumstances in which the counselor considers video mental health services appropriate and the possible advantages of providing those services online. For example, the potential benefits of video chat include the convenience for clients to potentially receive counseling from anywhere once an internet signal and necessary hardware is secured.

C. Potential risks: There are various risks related to electronic provision of counseling services related to the technology used, the distance between counselor and client, and issues related to timeliness. Confidentiality could be breached in transit by hackers or Internet service providers or at either end by others with access to the client's account or computer. Because of the risk to confidentiality, CentrePointe prohibits clients accessing the internet from public locations such as a library, computer lab, or café during Distance Counseling.

D. Safeguards: Your counselor has selected an account with Zoom via Ring Central for video communications to allow for the highest possible security and confidentiality of the content of your sessions. In order to benefit from these safeguards, the client is required to download, register and utilize the chat and video software from Zoom. Your personal information is encrypted and stored on a secure server in compliance with HIPAA regulations. The client is responsible for creating and using additional safeguards when the computer used to access services may be accessed by others, such as creating passwords to use the computer and maintaining security of their wireless internet access points. The counselor and client will also choose a password in the first session to be exchanged at the beginning of all subsequent distance sessions in order to verify the identity of the client. Please discuss any additional concerns with your counselor early in your first session to develop strategies to limit risk.

E. Crisis Procedures: The counselor might not immediately receive an online communication or might experience a local backup affecting internet connectivity. If the client is in a state of crisis or emergency (911), the counselor recommends contacting a crisis line or an agency local to the client. Clients may utilize the following crisis hotlines: 1-800-SUICIDE or 1-800-273-TALK (For the deaf or hard-of hearing: 1-800-799-4TTY).

F. Disconnection of Services: If there is ever a disruption of services on the internet every attempt will be made to restore connections and resume the counseling session. No additional time will be added to the session if there is a disruption of services. If the disruption of the connection or the degradation of the quality of the connect is determined to be the result of the client's equipment or internet service connection the counselor has the right to terminate the session and bill the client for the full session as an out-of-pocket expense.

G. Eligibility: Video counseling may not be appropriate for many types of clients including those who have numerous concerns over the risks of internet counseling, clients with active

suicidal or homicidal thoughts, and clients who are experiencing active manic/psychotic symptoms. An alternative to receiving mental health services online would be receiving mental health services in person. CentrePointe can and will assist clients who would like to explore face-to-face options in their area. Please feel free to request a referral at any time you think a different counseling relationship would be more practical or beneficial for you.

Having understood the nature and risks of therapy, the alternatives to treatment, the qualifications and values of the counselor, the nature of the fees and policies regarding cancellations, failure in technology, the limits and risks to confidentiality, the right to terminate therapy, and the right to voice a grievance, I consent to counseling (and/or video-based counseling when applicable) with this counselor and CentrePointe Counseling, Inc. I have read and understand the information contained in this document. I have been provided the opportunity to ask any questions of my counselor that I may have regarding video-based counseling and am satisfied I understand my rights and responsibilities in proceeding with this type of counseling.

Informed Consent for Therapy & HIPAA Notice of Privacy Practices

Having understood the nature and risks of therapy, the alternatives to treatment, the qualifications and values of the counselor, the nature of the fees and policies regarding cancellations, the limits to confidentiality, the right to terminate therapy, and the right to voice a grievance, I consent to treatment with this counselor and CentrePointe Counseling, Inc. I have read and understand the information contained in this document. **I have received a copy of the HIPAA notice of privacy practices.**

Client Signature (or parent/guardian of minor)

Date





**Voluntary Waiver of HMO/Insurance
Benefits**

(THIS FORM IS ONLY USED IF YOU ARE NOT USING INSURANCE FOR PAYMENT)

Signing this document will alter your legal rights under Maryland law. Please read carefully and do not sign unless you understand the document. I (client) _____ am seeking medical treatment from _____ (therapist).

Check One:

_____ 1. I am not a member of Health Maintenance Organization (HMO) and do not have private health insurance coverage (PPO, POS, etc.) and will be responsible for the payment of any amounts owed to my therapist for services provided.

_____ 2. I am a member of an HMO, but I have been informed that my therapist is not a participating provider with that HMO and that if my therapist provides services to me, I will be billed at my therapist's usual rate and I, instead of my HMO, will be responsible for full payment of that bill. I understand that if, instead of receiving treatment from my therapist, I had elected to obtain treatment from a health care provider participating in my HMO and the HMO determined that the service was covered under my benefit plan, I would be entitled to have this service reimbursed as set forth in that plan. Therefore, this means that I will be solely responsible for my therapist's charges. My therapist will not seek payment from my HMO.

_____ 3. I have private health insurance, but I have been informed that my therapist is not a participating provider with that insurance plan and that if my therapist provides services to me, I will be billed at my therapist's usual rate and I will be responsible for full payment of that bill. I understand that if, instead of receiving treatment from my therapist, I had elected to obtain treatment from a health care provider participating in my plan and the plan determined that the service was covered under my benefit plan, I would be entitled to have this service reimbursed as set forth in that plan. Therefore, this means that I will be fully responsible for my therapist's charges. My therapist will not seek payment from my insurance company. I can seek out-of-network reimbursement and the therapist will provide a receipt for me to attempt this. I understand that there is no guarantee that out-of-network reimbursement can be obtained for these therapy services.

_____ 4. I am using my EAP or Minister's Counseling Service (MCS) to pay for counseling sessions and therefore insurance will not be billed.

The undersigned agree that they are, at their request, choosing not to use their health insurance for coverage of fees with a CentrePointe counselor and will be fully and solely responsible for the charges incurred.

Client Signature _____ **Date** _____

Counselor Signature _____ **Date** _____



P.O. Box 1278 • Lincolnton, NC 28093
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www.centrepointecounseling.org

HIPAA Notice of Privacy Practices

Before beginning treatment or assessment, therapists MUST present this form to every patient. Patients' acknowledgment of receipt of this notice is required. (Note to therapists—Section I below MUST appear in your Notice of Privacy Practices exactly as it appears hereunder.)

I. 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.

II. It is my legal duty to safeguard your Protected Health Information (PHI).

By law, I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. **Use of PHI** means when I share, apply, utilize, examine, or analyze information within my practice. PHI is **disclosed** when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. However, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

III. How I will use and disclose your PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization. Others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and disclosures related to treatment, payment, or health care operations do not require your prior written consent.

I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care.

Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control—I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the

treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me. (For example, if you are unconscious or in severe pain, but I think that you would consent to such treatment if you could, I may disclose your PHI.)

B. Certain other uses and disclosures do not require your consent.

I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
4. If disclosure is compelled by the patient or the patient's representative pursuant to Maryland Health and Safety Codes or to corresponding federal statutes or regulations, such as the Privacy Rule that requires this Notice.
5. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
7. If disclosure is mandated by the Maryland Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.
8. If disclosure is mandated by the Maryland Elder/Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
14. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.

15. Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.
16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that may be of interest to you.
18. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
19. If disclosure is otherwise specifically required by law.

C. Certain uses and disclosures require you to have the opportunity to object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other uses and disclosures require your prior written authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

I. IV. What rights you have regarding your PHI.

These are your rights with respect to your PHI:

A. The right to see and get copies of your PHI. In general, you have the right to see your PHI that is in my possession or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.

If you ask for copies of your PHI, I will charge you not more than 25 cents per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The right to request limits on uses and disclosures of your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The right to choose how I send your PHI to you. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via fax instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

D. The right to get a list of the disclosures I have made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented,

i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

- E. The right to amend your PHI.** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.
- F. The right to get this notice electronically.** You have the right to get this notice electronically (it is available on our website www.centrepointecounseling.org). You have the right to request a paper copy of it, as well.

V. How to complain about my privacy practices.

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, DC 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. Person to contact for information about this notice or to complain about my privacy practices.

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at **CentrePointe Counseling Inc., P.O. Box 1278, Lincolnton, NC 28093.**

VII. Effective date of this notice—This notice went into effect on **April 14, 2003**