CentrePointe Counseling
P.O. Box 1278
Lincolnton NC 28093
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_____
Email Address_____

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?			
Caffeine			Recent Increase	Recent Decrease	Past Use
Alcohol			Recent Increase	Recent Decrease	Past Use
Tobacco			Recent Increase	Recent Decrease	Past Use
Marijuana			Recent Increase	Recent Decrease	Past Use
Pornography			Recent Increase	Recent Decrease	Past Use

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 $160 per 45-minute session, **except for the first session which is $190.** The professional counseling fee for group therapy is $75 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, as 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, regulating all licensed clinical social workers and professional counselors.

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 is a trained professional, and reserves time as scheduled, prepares for each session and actively listens and gives constructive feedback.

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

Office Policies and Procedures

Confidentiality

You are entitled to confidentiality in the counseling relationship, to the extent of the law. All mental health professionals are required by law to suspend confidentiality if there is a clear indication that a client may injure him/herself or others. Mental health professionals must also report any physical or 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 medications, prescription or other, including dosage. If taking medication prescribed by a physician, you are expected to follow the prescribed dosage. Seek your physician regarding problems with prescribed medications or dosages.

Alcohol and Substance Use and Abuse

If you struggle with substance abuse, you are nevertheless to refrain from alcohol and drug use. Attending counseling sessions while intoxicated will not be tolerated. If intoxicated, clients will be dismissed and the full counseling fee will be payable.

Emergencies or Crises

If you are experiencing an emergency or crisis, do not call your counselor; instead, direct your call to 911 or go to your nearest emergency room. You may request hospital staff to contact your counselor.

Court Appearance Requests

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

Emails & Phone Calls to Your Counselor

Emails to counselors are restricted to records requests and non-clinical, non-emergency matters. All email communication is included in your medical chart and can become part of a document for legal use. Please allow 72 hours for your counselor to respond. If no response is received in that time, contact the office.
S essions over the telephone or live video chat may be arranged, depending on your insurance coverage and limitations based upon your State of residence. Sessions over the telephone or by video chat will be charged at the regular rate.
Please do not contact your counselor's office location staff where therapy sessions are conducted (church or association office). Staff members at church offices do not work for CentrePointe, and would violate the confidentiality of your sessions if they interacted with you.

Informed Consent for Therapy & HIPAA Notice of Privacy Practices

I understand the nature and risks of therapy, the alternatives to treatment, the qualifications and values of the counselor, the nature of 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_____

Insurance Reimbursement

I give my counselor and CentrePointe Counseling, Inc. permission to submit claims to my insurance company for reimbursement. I understand my responsibility for payment if insurance does not cover my sessions.

Client Signature_____

Consent to Use or Disclose Information
for Treatment, Payment, and Health-Care Operations (TPO)

Federal regulations (HIPAA) allow CentrePionte to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for services provided, and for other professional activities (known as *health-care operations*). Nevertheless, CentrePointe asks for your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in further detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. Revised Notices will be posted in the office. You may ask for a printed copy of our Notice at any time. You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health-care operations. However, CentrePointe does not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding. You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation. This consent is voluntary. You may refuse to sign it. However, CentrePointe is permitted to refuse to provide health-care services if this consent is not granted or if the consent is later revoked.

I hereby consent to the use/ disclosure of my Protected Health Information as specified above.

Client/Patient Name _____

Client (or parent) Signature _____ **Date:**_____

Email Communication

I agree to allow my counselor and the office staff to contact me via email. I understand that a notice of confidentiality will be attached to all email communications from this office. I understand that this authorization may be revoked by me at any time in writing.

Client (or parent) Signature _____ **Date:**_____

Email address: _____

Guardianship - Please complete if the counseling client is a minor (under age 16)

As parent, guardian, or legal custodian, I (we) give permission for counseling by _(counselor) and CentrePointe Counseling, Inc. for_____(client). I (we) understand that the above named counselor is providing professional services to and on behalf of the above named client. I (we) agree to assume full responsibility for payment of all reasonable charges by the above-named counselor and CentrePointe.

Date _____

Signature(s) _____ _____

Name(s) (print) _____ _____

Address _____ _____

_____ _____

Home Telephone _____ _____

Relationship to Client _____ _____

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.

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 pan, 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 pan, 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**_____

Application for Samaritan Fund Grant and Sliding Scale Fee

v02.20

This application is for a grant to assist with accessing CentrePointe counseling. Grants are based on current income and assets; a co-pay is typically required. Grant renewal requires submission of updated information.

Please submit with proof of income: a recent paycheck stub, or copy of the first page of most recent tax return.

- Submit the following to admin@centrepointecounseling.org: **completed application** *AND* **a copy of your paycheck** or **first page of most recent tax return**. Application must be complete to be considered.
  *Photos/scanned copies of your paycheck or tax return should be clear and readable.
- Alternatively, fax the above items to: 301-774-3678
- We recommend all clients call their medical insurance companies to inquire about Out-of-Network Insurance Benefits for Mental/Behavioral Health Services.
- Upon review, you will be sent an email with the result of your application; your counselor will be cc'ed. You will be notified of the number of sessions approved and the amount, if any, of your co-pay. Once grant-approved sessions have been completed, further sessions may be requested and will require new applications to be submitted for review.
- **All information will be held confidential and will not be shared with any outside party**. Questions? Please discuss with your counselor or contact admin@centrepointecounseling.org

Personal Information

Name: _____ Age: _____ Date: _____

Email Address: _____ Phone: _____

☐Full-time Work ☐Part-time Work / Hours per _____ Employer: _____

☐Not Employed ☐Full-time Student ☐Part-time Student School: _____

☐New CentrePointe Client ☐Current/Former client – counselor: _____ ☐I have church (or organization) sponsorship: $ _____

Spouse (or Family Member, if providing support), Dependents

Name: _____ Occupation and Status: _____

Employer: _____

Number of Dependents in family: _____

Names and Ages: _____

Annual Income

Please enter **Adjusted Gross Income** (pre-tax) of most recent tax return: $ _____ Year: _____

☐Single Return ☐Joint Return

Has your employment changed since your last tax return? ☐Yes ☐No

If yes, explain: _____

Has your household/family income changed since your last tax return? ☐Yes ☐No

If yes, explain: _____

Current Monthly Income: Personal & Spouse/Family Supporter Income

Gross monthly wages or salaries (pre-tax) of personal income (include severance pay): $ _____

Gross monthly wages or salaries (pre-tax) from spouse/family supporter: $ _____

Monthly income, other sources (for example: unemployment, rental property, SSI, SSDI, stocks, bonds, trust fund, cash gifts, other): $ _____

Gross Monthly Total: $ _____

Savings & Assets (Not including real-estate or retirements funds)

Do you have a savings account, stocks (matured/vested), bonds, mutual funds or a trust fund? ☐Yes ☐No

If so, what is the value: ☐below $50,000 ☐$50,000 - $199,999 ☐$200,000 - $499,999 ☐$500,000+

DEBT (total obligation)

Mortgage $ _____

Automobile(s) $ _____

All credit cards $ _____

Other, total (please specify): _____ $ _____

Total Debt: $ _____

Comments & Additional Information

Is there any additional information you would like us to consider?

_____

Signed: _____ **Date**: _____

CentrePointe Counseling

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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 of 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**