

CLIENT INFORMATION FORM

Date		Client Name	
Email			
Phone	(H)	(C)	(W)

Parent Information (if client is under the age of 18)

Parent (1) Name					
Email					
Phone	(H)	(C)	(W)		
Parent (2) Name					
Email					
Phone	(H)	(C)	(W)		

Home Address (for minors, list address of primary residence)

Who referred you to our office?

Georgetown Office
1054 31st St, NW
Suite 312
Washington, DC 2000
(202) 333-6251

McLean Office
1355 Beverly Rd
Suite 320
McLean, VA 22101
(703) 556-6655

Bethesda Office
4915 Auburn Avenue
Suite 303
Bethesda, MD 20814
(301) 652-5550

AUTHORIZATION TO CHARGE CREDIT CARD

Date: _____

I hereby authorize Georgetown Psychology Associates to charge my credit card after each visit for services provided for myself or my child, _____.
(Print Full Name)

Name as it appears on the card					
Credit Card Number					
Expiration Date			Security Code		
Billing Address					
City		State		Zip Code	

Please provide the email address where you would like your invoice sent to:

(Email Address)

By signing this form, I consent to the charge(s) to my credit card, as well as email communication.

Signature of Client or Responsible Party

Date

Print Name and Relationship

FOR OFFICE USE ONLY:

ICD-10 Code: _____

CPT Code: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Georgetown Psychology Associates to seek and share the following information regarding my child, (Name) _____, (Date of Birth) _____, for the purpose of:

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Person(s) with whom Georgetown Psychology Associates may exchange information:

Name	Address	Phone Number

INFORMATION TO BE SHARED

History/Treatment/Opinion
 Previous/Current evaluations and reports

I understand that this authorization is valid for one year from date of signing and can be revoked at any time by providing written notice of such revocation to Georgetown Psychology Associates.

Parent 1* Signature and Date

Print Name

Parent 1* Address

Phone Number

Parent 2* Signature and Date

Print Name

Parent 2* Address

Phone Number

(*signature of both parents required unless adult or documentation of sole custody or court ordered guardianship is attached to consent form)

THERAPIST-CLIENT SERVICE AGREEMENT

Welcome to our practice. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our first session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods we may use to deal with problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

The first few sessions will involve an evaluation of you (or your child's) needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, money, and energy, so you should be thoughtful about the therapist you select. If you have questions about our procedures, we should discuss them as they arise. If your doubts persist, we would be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

We normally conduct an evaluation that will last from 2 to 4 sessions. The first session is a formal intake appointment, which lasts 60 minutes. During this time, you and your therapist can decide if he/she is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, we will usually schedule one 45-minute session per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment is scheduled, you will be expected to pay for it. **We require 48-hour notice to cancel or reschedule an appointment.** It is important to note that insurance companies do not provide reimbursements for cancelled sessions.

○ Client acknowledgment _____.

Disclaimer for Georgetown University Student Health Insurance:

We require 48-hour notice to cancel or reschedule an appointment. It is important to note that insurance companies do not provide reimbursements for cancelled sessions. Based on information provided to us by your insurance company, we will charge you for your coinsurance as well as any deductible amount that is indicated as the patient responsibility per session. You will be responsible for the full amount the insurance would pay plus your co-insurance amount if you fail to give us 48-hours' notice to cancel your appointment.

○ GUSHI student acknowledgement _____.

PROFESSIONAL FEES

In addition to weekly appointments, we charge fees for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, completing insurance forms, conducting school observations (including travel time), telephone conversations lasting longer than 10 minutes, consulting with other professionals (with your written consent), preparation of records or treatment summaries, and the time spent performing any other service you may request. If you become involved in legal proceedings that require our participation, you will be expected to pay for all professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge \$500.00 per hour for preparation and attendance at any legal proceeding. The expected fee is collected prior to the legal proceeding.

CONTACTING YOUR THERAPIST

Due to our schedules, we are often not immediately available by telephone. We employ an answering service that takes messages in our absence. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. In situations that require prompt attention, you may contact Dr. Maria Zimmitti via cell phone (202.374.4447); please use this number in emergencies only. If you are difficult to reach, please inform us of times when you will be available. If you are unable to reach your therapist or Dr. Zimmitti and feel that you cannot wait for us to return your call, please call 911 or go to your nearest emergency room and ask for the psychologist or psychiatrist on call. If your therapist will be unavailable for extended time, we will provide you with the name of a therapist/colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a therapist. In most situations, we can only release information about your treatment to others if you sign a written authorization. This Authorization will remain in effect for a length of time you determine. You may revoke the authorization at any time, unless we have taken action in reliance on it. However, there are some disclosures that do not require Authorization, as follows:

- You should be aware that we practice with other mental professionals and that I employ administrative staff. In most cases, we need to share protected information with these individuals for administrative purposes, such as scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- We also have contracts with BEi (IT company), Clemencia Barnes (cleaning service), Pedro Ordonaz (cleaning service), Cathedra Capital (CFO), and Accordia Consulting (accounting service). As required by HIPAA, we have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. We cannot provide any

information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.

- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a patient files a complaint or a lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.
- If a patient files a worker's compensation claim, we must, upon appropriate request, provide a copy of the patient's record to the D.C./MD/VA Office of Hearings and Adjudications, the patient's employer or insurer.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect a patient or others from harm, and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice.

- If we know or have reason to suspect that a child has been or is in immediate danger of being mentally or physically abused or neglected, the law requires that we file a report with the appropriate governmental agency, usually the Child Protective Services Division of the Department of Human Services. Once such a report is filed, we may be required to provide additional information.
- If we have substantial cause to believe that an adult is in need of protective services because of abuse, neglect or exploitation by someone other than our patient, the law requires that we file a report with the appropriate governmental agency, usually the Department of Human Services. Once such a report is filed, we may be required to provide additional information.
- In an emergency, if we believe that a patient presents a substantial risk of imminent and serious injury to him/herself, we may be required to take protective actions, including notifying individuals who can protect the patient or initiating emergency hospitalization.
- If we believe that a patient presents a substantial risk of imminent and serious injury to another individual, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, we will make every effort to fully discuss it with you before taking action and we will limit our disclosure to what is necessary.

In all other situations, we will ask you for an advance authorization before disclosing any information about you. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. That laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve a substantial risk of imminent psychological impairment or imminent serious physical danger to yourself and others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to

another mental health professional so you can discuss the contents. In most situations, we are allowed to charge a copying fee of \$0.15 per page (and for other expenses). The exceptions to this policy are contained in the attached Notice Form. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

In addition, we may also keep a set of Psychotherapy Notes. These Notes are for our own use and are designed to assist us in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of conversations with clients, our analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to us that is not required to be included in your Clinical Record [and they also include information from others provided to us confidentially]. These Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

PATIENT RIGHTS

You may have certain rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINOR & PARENTS

Psychologists can provide psychological services to minors without parental consent if the psychologist determines that the minor is knowingly and voluntarily seeking the services and provision of the services is clinically indicated for the minor's well-being. These services can only be provided for 90 days but can be continued if the psychologist re-determines that the services are still clinically indicated. Parents do not have access to records of this treatment. Patients under 18 years of age but who are over 14 and not emancipated and whose parents have consented to treatment should be aware that parents can only review the child's records with the written authorization of the child. Children under 14, whose parents have consented to the treatment, should be aware that their parents can examine their treatment records unless we decide that such access is likely to injure the child, or we all agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and because it is important for parents to have some information about their child's treatment, it is usually our policy to request an agreement of both the parents and child about what information parents will receive about their child's treatment. If the patient agrees, during treatment, we will provide parents only with general information about progress of the child's treatment, and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay at each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or payment installment plan. We ask that you complete a credit card authorization form (attached) which we will bill at the time of your session. We will email you an

itemized invoice at the end of each month that you may then submit to insurance. We accept Visa, MasterCard, Discover, and American Express.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its cost will be included in the claim.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, **you (not your insurance company) are responsible for full payment of our fees as services are rendered**, as we are not in-network with any insurance companies. It is very important that you find out exactly what mental health services your insurance policy covers. Some insurance companies require pre-authorization paperwork to be completed before they will approve sessions. We will ask you to fill out an authorization if we are asked to provide information to your insurance company of HMO that will allow us to provide the information necessary to help you secure payment for the services we provide for you. This Authorization will be in effect for one year, but can be revoked at any time.

You should carefully read this section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be willing to call the company on your behalf. Due to rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company may require that we provide it with information relevant to the services that we provide to you. This is typically limited to diagnostic information, including a treatment plan, the reasons for continuing treatment and the prognosis of how long the treatment will need to continue. If the Insurance Company determines that more information is necessary, the insurance company must appoint an independent reviewer and the additional information can only be disclosed to the reviewer. You should also be aware that some self-insured employee benefit plans are not subject to this law. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested.

This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the issues described above.

ACKNOWLEDGMENT

Your signature below indicates you have read this agreement and agree to its terms, and also serves as an acknowledgement that you have received (in person or electronically) the Georgetown Psychology Associates' Notice of Privacy as well as the Electronic Communication Policy as described below.

Client / Parent or Guardian Signature

Date

Parent 2 Signature*

Date

***Note:** If you are currently separated or have a joint custody agreement in place, both parents must sign this form. Both signatures are also required when one parent has legal/medical decision-making authority. Therapy cannot be initiated without the expressed consent of both parents. If you have a sole custody agreement in place, please submit documentation to your therapist prior to your first appointment.

REFUSAL TO SIGN ACKNOWLEDGEMENT

Client / Parent or Guardian Signature

Date

ELECTRONIC COMMUNICATION POLICY

In order to maintain clarity regarding our use of electronic communication during your treatment, Georgetown Psychology Associates has prepared the following policy.

Various types of electronic communication are common in our society, yet while many people prefer this mode of contact with others for either social or professional purposes, it may put your privacy at risk. Moreover, such communication can be inconsistent with the law and with the standards of our profession. Consequently, this policy has been prepared to ensure the security and confidentiality of your treatment and to assure its consistency with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with your therapist.

EMAIL COMMUNICATION

We use email communication only with your permission, and only for administrative purposes, unless we have made another agreement. As such, email exchanges with our office should be limited to setting and changing appointments, coordinating billing, and other related issues. As email is not a secure method of contact, we ask that you do not email your therapist about clinical matters. If you need to discuss a clinical matter with your therapist, please feel free to call them during your next therapy session or wait to discuss it. Communicating by phone or face-to-face are more secure modes of communication.

TEXT MESSAGING

Because text messaging is an unsecured and impersonal mode of communication, we neither send nor respond to text messages to or from clients. As such, we ask that you please do not communicate via text message, unless alternate arrangements have been made.

SOCIAL MEDIA

We do not communicate with any clients through social media platforms such as Twitter or Facebook. If we discover that we have accidentally established an online relationship with you, the connection will immediately be removed, as casual social contacts may create a significant security risk for you.

Although we may participate on various social networks, it is not in our professional capacity. If you have an online presence, there is a possibility that you may encounter your therapist unintentionally. If so, please discuss it with him/her during your next session. We believe that any communication with clients online has the potential to compromise the professional relationship. Please do not try to contact your therapist via social networks, as we are unable to respond and will not engage in online communication.

WEBSITES

Georgetown Psychology Associates has a website that provides information about our practice and professional services. You are welcome to access and review the information on the website and discuss any questions during your therapy sessions.

WEB SEARCHES

Your therapist will not use web searches to gather information about you without your permission. We believe that this violates your right to privacy. Nevertheless, we understand that you may wish to gather information about your therapist in this way.

An incredible amount of personal information is widely available on the internet, including that which is provided with an individual's knowledge and consent, as well as information that may be inaccurate or unknown. If you encounter any information about your therapist through web searches, or in any other manner, please discuss it with him or her during your session. This will allow you and your therapist to maintain an open dialogue, and for any potential impact on your treatment to be considered.

Recently, it has become common for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to comments or related errors because of confidentiality restrictions. If you encounter such reviews of any professional with whom you are working, please discuss this with your therapist so any potential impact on your therapy can be discussed. Please do not rate your therapist's work with you while in treatment on any of these websites, as it may damage the ability for you and your therapist to work together.

NOTICE OF 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 written authorization. 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 of treatment would be when we consult with another health care provider, such as your family physician or another therapist.
 - *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.
 - *Healthcare Operations* are activities that relate to the performance and operation of our practice. Examples of healthcare 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 such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

- “*Disclosure*” applies to activities outside of our group practice such as releasing, transferring, or providing access to information about you to other parties.
- “*Authorization*” is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other 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. In those instances when we are 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 our 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 without Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances: This includes narrowly-defined disclosures of law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

- Child Abuse - If we have reason to believe that a child has been subjected to abuse or neglect, we must report this belief to the appropriate authorities.
- Adult and Domestic Abuse - If we have reason to believe that an adult is in need of protective services because of abuse or neglect by another person, we must report this belief to the appropriate authorities.
- Health Oversight Activities - If we receive a subpoena from a board of psychology or social work in Maryland, DC or Virginia, we must disclose the relevant PHI pursuant to that subpoena or lawful request.
- Judicial and Administrative Proceedings - If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization 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 if this is the case.
- Serious Threat to Health or Safety - If you communicate to us a specific threat of imminent harm against another individual or if we believe that there is clear, imminent risk of physical or other mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider necessary to protect you from harm.

IV. Patient’s Rights and Therapist’s Duties

You have the following rights regarding the PHI that this office maintains about you.

- 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 being seen at our office. On your request, we will send your bills to another address.) You will be provided with a form on which to list your authorized means of communications. It will be understood that there may be times when you may provide your therapist with additional ways in which to communicate, outside of those listed on the form you have signed. It will be understood that these also will be considered patient authorized confidential communications. (For example, you are out of town and wish to speak to your therapist. In such a case, you may leave a voicemail providing your therapist with a contact number, other than those listed on your authorization form, by which to communicate with you at the location where you are.)
- Right to Inspect and Copy - You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about your for as long as the PHI is maintained in the record. To inspect and/or obtain a copy of your PHI, you must complete our request form and submit it to the Privacy Officer. If you request copies, we will charge you \$0.10 per page. 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.
- Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. In addition, you must provide a reason that supports your request. 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 an 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.
- Right to be Notified if There is a Breach of Your Unsecured PHI – You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

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.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact your therapist and/or Dr. Maria Zimmitti at 301-652-5550.

If you believe that your privacy rights have been violated and wish to file a complaint with us/our office, you may send your written complaint to your therapist and/or Dr. Maria Zimmitti at 4915 Auburn Avenue, #303, Bethesda, MD 20814.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you or penalize you in any way for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003. Updated July 2018.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. If we revise our policies and procedures, we will post a copy of any revised Notice in this office.