INFORMED CONSENT

Introduction: This agreement is intended to provide you with important information regarding the practices, policies and procedures of THE FAMILY GUIDANCE AND THERAPY CENTER OF SOUTHERN CALIFORNIA and to clarify the terms of the professional therapeutic relationship between your therapist, _____and you/your family. If you are a parent of a minor client, then you will need to consent to their treatment prior to the commencement of services. Any questions or concerns regarding the contents of this Agreement should be discussed prior to signing it. Please read the entire document carefully and ask any questions before signing the document. Please initial each section to indicate that you have read and understood that particular section.
_____ Initial

Practice Information: The individual marital and family therapist who operates this practice is Jennifer Palmiotto. Her license number is #47375. This practice is a Licensed Marriage and Family Therapist Corporation: THE FAMILY GUIDANCE AND THERAPY CENTER OF SOUTHERN CALIFORNIA. This professional corporation operates under the fictitious business name of THE FAMILY GUIDANCE AND THERAPY CENTER OF SOUTHERN CALIFORNIA.
_____ Initial

Therapist Background and Qualifications: At your request, I will discuss my professional background information with you and provide you information regarding my experience, training, special interests, and professional orientation. You are free to ask questions at any time about my background, experience and professional orientation.
_____ Initial

Professional Services Rendered: The Family Guidance and Therapy Center of Southern California offers several services including psychotherapy. Psychotherapy may involve one individual, the whole family, couples, or group therapy, RDI consultation, educational and behavioral services.
_____ Initial

Process of psychotherapy: There are many reasons that people come to therapy. Therapy will include an initial assessment, treatment planning, and face-to face sessions. Before treatment begins, we will determine who needs to attend sessions. Depending on your individualized treatment plan, we may work on improving communicate, solving problems, developing or strengthening coping strategies, learning to maintain positive interactions, practicing techniques, parent training, or self-exploration. All

therapy will promote healthier and more satisfying relationships. I use a variety of interventions including dialogue, expressive arts, imagery, role playing, homework assignments, along with other modalities and interventions. Clients can at any time ask questions about their treatment.
_____ Initial

Risks and Benefits of Therapy: Psychotherapy is a process in which we discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so clients can experience life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties clients maybe experiencing. Psychotherapy is a joint effort between the client(s) and the therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Participating in therapy may result in a number of benefits, including, but not limited to, reduced stress and anxiety, increased ability to relate to others, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in school, social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of the client(s), including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above. Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which clients perceptions and assumptions are challenged, and different perspectives offered. The issues presented by clients may result in unintended outcomes, including changes in personal relationships. Clients should be aware that any decision on the status of his/her personal relationships is your responsibility. During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. You may address any concerns you have regarding progress during your session. If you are the parent/representative of a client, there are limits to what will and will not be discussed in the course of treatment. These expectations will be clarified with your be-fore treatment begins.
_____ Initial

Professional Consultation: Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personal identifying information concerning clients.
_____ Initial

Records and Record Keeping: I will keep records in accordance with the ethical and legal standards of my profession. Records may be re-quested at any time in writing. Records will be stored in a locked file cabinet or by a secured on-line practice management software system. Records will be kept for 7 years after you've terminated therapy.
_____ Initial

Use of Practice Management Software: MyClientsPlus software is fully secure, confidential, encrypted, HIPAA-compliant practice management software.
_____ Initial

E-mails, Cell Phones, Computers and Faxes: It is very important to be aware that computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. While data on FGTC providers' laptops is encrypted; e-mails and e-fax are not. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. FGTC providers' laptops are equipped with a firewall, a virus protection and a password, and providers back up all confidential information from their computers on a regular basis onto an encrypted hard-drive. Also, be aware that phone messages are transcribed and sent to FGTC providers via unencrypted e-mails. Please notify your FGTC provider if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, FGTC will assume that you have made an informed decision, and will view it as your agreement to take the risk that such communication may be intercepted, and FGTC will honor your desire to communicate on such matters. Initial below if you consent to to communicate by email, text and voicemail. *Please do not use texts, e-mail, voice mail, or faxes for emergencies.*
_____ Initial

Participation in Litigation: I will not voluntarily participate in any litigation, or custody dispute in which client and another individual, or entity, are parties. I have a policy of not communicating with client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in a legal matter unless agreed upon at beginning of the therapeutic relationship. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving a client, client agrees to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate of$150.00/hour.
_____ Initial

Psychotherapist-Patient Privilege: The information disclosed by client, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. If I received a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-patient privilege on client's behalf until instructed, in writing, to do otherwise by client or client's representative. Client should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Client should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.
_____ Initial

Notice of Privacy Practices: This practice is HIPAA compliant. Please indicate that you have received and signed the document named "Notice of Privacy Practices." This document further explains how your medical information will be used by this practice.

_____ Initial

Confidentiality: All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release.

_____ Initial

Exceptions to confidentiality: There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

_____ Initial

Minors and Confidentiality: Communications between therapists and patients who are minors (under the age of 18) are confidential. How-ever, parents and other guardians who consented for their child's treatment are often involved in their treatment. Within my professional judgment, I will discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

_____ Initial

Fee and Fee Arrangements for Psychotherapy: The usual and customary fee for psychotherapy and educational service is _____/hour. Your appointment will be for _____ minute session. An additional_____ minutes will be used for record keeping. Sessions longer than your scheduled appointment are charged for the additional time pro rata. I reserve the right to periodically adjust this fee. You will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payers. From time-to-time, I may engage in telephone contact with you for purposes other than scheduling sessions. You will be responsible for payment of the agreed upon fee on a pro rata basis. In addition, from time-to-time, I may engage in telephone contact with third parties at client's request and with client's advance written authorization. Client is responsible for payment of the agreed upon fee (on a pro rata basis). Clients are expected to pay for services at the time services are rendered. Cash, credit card, or checks are accepted.

_____ Initial

Return check Policy: You be responsible for the amount of any returned checks plus a $17.00 returned check fee which includes bank fees and administrative costs.

_____ Initial

Cancellation Policy: You are responsible for payment of the agreed upon fee for any missed session(s). You are also responsible for payment of the agreed upon fee for any session(s) for which you failed to give at least 24 hours' notice of cancellation. Cancellation notice should be left on company voicemail at 619-600-0683.
_____ Initial

Therapist Availability: My office is equipped with a confidential voicemail system that allows a client to leave a message at any time. You may contact me at 619-600-0683 ext ____. I will make every effort to return calls within 24 hours (or by the next business day), but can-not guarantee the calls will be returned immediately. I am unable to provide 24-hour crisis service. In the event that client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room. In the event that I am unable to attend our schedule appointment, I will contact you via your preferred method of communication to cancel and re-schedule the session. You will be notified in advance of vacations or planned extended absences. You and I will determine a revised treatment plan prior to the absence.
_____ Initial

Use of Telemedicine: This practice uses telemedicine as part of treatment. Telemedicine includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications, and e-mail. Telemedicine also involves the communication of your medical/mental information, both orally and visually, to health care practitioners located in California or outside of California. You have the following rights with respect to telemedicine: (1) you have the right to with-hold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any pro-gram benefits to which I would otherwise be entitled. (2) The laws that protect the confidentiality of your medical information also apply to telemedicine. As such, the information disclosed by you during the course of you therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where you make your mental or emotional state an issue in a legal proceeding. The dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your written consent. (3) There are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of your psychotherapist, that: the transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your medical information could be interrupted by unauthorized persons; and/or the electronic storage of your medical information could be accessed by unauthorized persons. In addition, please understand that telemedicine based services and care may not be as complete as face-to-face services. I will advise you if you would be better served by another form of psychotherapeutic services (e.g. face-to-face services). You will be referred to a psychotherapist who can provide such services in your area. Finally, there are potential risks and benefits associated with any form of psychotherapy, and that despite your and my efforts, your condition may not be improve, and in some cases may even get worse. (4) You may benefit

from telemedicine, but that results cannot be guaranteed or assured. (5) You have a right to access your medical information and copies of medical records in accordance with California law. You may discuss the use of telemedicine with me at any time.
_____ Initial

Termination of Therapy: You may terminate therapy at any time. I, also, reserve the right to terminate therapy at my discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, client needs are outside of my scope of competence or practice, or client is not making adequate progress in therapy. You also have the right to terminate therapy at your discretion. Upon either party's decision to terminate therapy, I will generally recommend that client participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. I will also attempt to ensure a smooth transition to another therapist by offering referrals to client, if requested.
_____ Initial

Questions or Complaints: If you have any questions about this no-tice or any complaints about my privacy practices, or would like to know how to file a complaint with the Board of Behavioral Sciences or the Secretary of the Department of Health and Human Services, please contact me at: The Family Guidance & Therapy Center of Southern California, 3575 Kenyon Street, Suite 102, San Diego, CA 92110 to discuss your concerns.
_____ Initial

Acknowledgement: By signing below, client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed such terms and conditions with their therapist and has had any questions with regard to its terms and conditions answered. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy or other services with Therapist. Moreover, client agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.
_____ Initial

I, _____, have read this Informed Consent document, I understand it and agree to comply.

_____
Child/Minor Name (If applicable)

_____ _____
Printed Parent/Guardian Name **Relationship to Client**

_____ _____
Signature **Date**

PERSONAL HISTORY FORM

Please complete and return. If you would like to provide additional information, please use the back of the form. Please submit any educational, neurological, or psychological records that you feel would benefit the therapist in learning about your you or your child.

General Information

Client Name:	Today's Date:	Sex:
Name of person completing form:	Client DOB:	Preferred contact phone #:
Relationship to client:	Social security #:	Alternative phone #:
Address:	Email address:	Emergency contact name/#:

Seeking the following Services:

- ☐ Relationship Development Intervention (RDI)
- ☐ Individual Therapy
- ☐ Behavioral Therapy
- ☐ Parent Training
- ☐ Couples Therapy
- ☐ Educational Consultation
- ☐ Group Therapy
- ☐ Family Therapy
- ☐ Pre-marital Therapy
- ☐ Other: please specify _____

Primary reason(s) for seeking services:

- ☐ Relational Issue
- ☐ Autism Spectrum
- ☐ Anger Management
- ☐ Work Issue
- ☐ Social Issues
- ☐ Parenting Issues
- ☐ Family Problems
- ☐ Development Delays
- ☐ Anxiety
- ☐ Coping
- ☐ Fear/phobias
- ☐ Compulsive Behaviors
- ☐ Depression
- ☐ Sexual Concerns
- ☐ Alcohol/Drugs
- ☐ Eating Disorder
- ☐ Sleeping problems
- ☐ Hyperactivity

Other mental health concerns (specify):

_____

_____

Please select:

___American Indian ___Asian ___Black ___ Hispanic ___Pacific Islander ___White

___Two or more races ___Other

Language(s) spoken at home: _____

Please answer the following questions to the best of your ability:

1. Goals: What are your goals for coming here? Please be as specific as possible.

_____

_____

2. Medical History: Please share anything notable about you or your child's medical status, including neurological problems and allergies.

- ☐ Abortion
- ☐ Asthma
- ☐ Blackouts
- ☐ Bronchitis
- ☐ Hives
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Congenital problems
- ☐ Croup
- ☐ Diabetes
- ☐ Sexually transmitted disease
- ☐ Dizziness
- ☐ Ear aches
- ☐ Ear infections
- ☐ Eczema
- ☐ Encephalitis
- ☐ Fevers
- ☐ Hay fever
- ☐ Heart trouble
- ☐ Hepatitis
- ☐ Hearing
- ☐ Rheumatic Fever
- ☐ Influenza
- ☐ Lead poisoning
- ☐ Measles
- ☐ Meningitis
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Muscular Dystrop
- ☐ Nose bleeds
- ☐ Other skin rashes
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Polio
- ☐ Pregnancy
- ☐ Speech
- ☐ Sensory/Motor

- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Severe Colds
- ☐ Meningitis
- ☐ Headaches
- ☐ Thyroid disorders
- ☐ Vision problems
- ☐ Wearing glasses
- ☐ Whooping cough
- ☐ Other _____

List any current health concerns: _____

_____

_____

List any recent health or physical changes: _____

_____

_____

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over the counter medications	Dose	Dates	Purpose	Side effects

3. Counseling/Prior Treatment History: Please share with me about any prior counseling that you or your child has received. What worked? What did not work?

Insurance Information Form

If you will be seeking reimbursement from insurance.....

Insurance Company:	Policy Holder Name:	Relationship to client:
Group ID:	Plan ID:	Membership ID:
Policy Holder's Social Sec. #:	Policy Holder's place of employment:	Gender of Policy Holder
Address:	Policy Holder's Birthdate:	Do you have any other insurance policies?

Contact number for insurance company (on back of card): _____

Additional information that you feel is important for your therapist to know:

Credit Card Authorization Form

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I authorize The Family Guidance and Therapy Center of Southern California to charge my credit/debit card for professional services as follows:

Please initial:

____ Recurring charges for services in the amount of $_____ per visit.

____ I understand and agree that my card will be charged full fee for cancellations with less than 24 hours' notice and for appointments I miss without notice.

____ I understand this form is valid for one year unless I cancel the authorization in writing. I will not dispute charge ("charge back") for sessions I have received or appointments I missed according to the above policy.

____ When using my health insurance to pay for therapy, I am responsible for any co-pays, deductibles, and co-insurance. If for whatever reason, claims are denied, I am responsible for the fees owed. Health insurance never pays for late cancel or no show appointments. I will be responsible for the fee for service in the event that I cancel.

I, _____, am authorizing The Family Guidance and Therapy Center of Southern California the use of my credit card in the event that I do not notify my therapist of my inability to attend a scheduled therapy appointment and/or do not cancel my appointment at least 24 hours in advance as agreed to in the informed consent form signed.

Card Type (circle one): Visa MasterCard

Card #:_____ Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code: (3 digit code on back by signature) _____

Billing Address for Card: _____
(Street, City, State and Zip)

Phone # associated with card: _____

Signature: _____ Date: _____

Notice of Privacy Practices

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. I am legally required to follow the privacy practices described in this Notice. 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 will not. Below you will find the different categories of my uses and disclosures.

A. Uses and disclosures related to treatment, payment, or health care operations that do not require your prior written consent. I may use and disclose your PHI without your consent for the following reasons:
   i. 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.
   ii. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
   iii. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and service I provide you.
   iv. Other disclosures. 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, e.g., 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 that do not require your consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:
   i. When federal, state, or local law; judicial board, or administrative proceedings; or, law enforcement requires disclosure.
   ii. 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.
   iii. 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.
   iv. If disclosure is mandated by the California Child Abuse and Neglect Reporting law.
   v. If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law.
   vi. For Public Health activities, e.g., in the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
   vii. For health oversight activities, e.g., 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.
   viii. For specific government functions, e.g., 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.
   ix. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
   x. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.
   xi. Appointment reminders and health related benefits or services. 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.
   xii. If disclosure is otherwise specifically required by law.

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

IV. **What rights you have regarding you PHI?**

These are your rights with respect to your PHI:

A. The right to view and obtain copies of your PHI. In general, you have the right to view your PHI that is in my possession or to obtain copies of it. 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 obtain it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may deny your request. If your request is denied, you will be given 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 $0.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree in advance to it, as well as to the cost.

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 or by an alternate method, e.g., email. 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, e.g., 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 30 days of receiving your request. The list I provide to 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 the 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 by email. You have the right to get this notice by email. 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, D.C., 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:

The Family Guidance Center of Southern California
3575 Kenyon St. Ste. 102
San Diego, CA 92110

I acknowledge receipt of this notice.

Printed Name/Relationship to Client: _____

Date _____

Signature: _____

Patient name (if minor): _____