Gabriel Villarreal Resident in Counseling

ADHD Counseling in the Roanoke Valley

Adult Intake Form

Client's Name ____ Date___________________

SSN ____________________ DOB____________ Age______ Gender______________

Street____ City___________ State___ Zip_____

Home phone________________________ May we call you at home? Yes/No

Cell phone __________________________ May we call your cell? Yes/No

Employer____________________ Work phone ________________
May we call you at work? Y/ N

Marital Status __________________ Spouse's Name________________________ DOB ______

In case we can not contact you and need to leave a message, whom should we contact?

Name___________________________ Telephone Number______________
Relationship_________________

How did you learn about my counseling services?
( ) Friend ( ) Family ( ) Google ( ) Physician: ____________________
( ) Other _____________________________

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Practice Policies

Tanglewood Counseling and Psychology consists of four mental health professionals. We are each in independent practice. We are not a partnership and we do not see one another's clients unless a consultation is specifically requested.

Fees: Counseling Services provided by Gabriel Villarreal, Resident in Counseling, will be offered at **$125 for the first session (intake),** and **$100 for concurrent sessions**. Only checks and cash are accepted. Gabriel Villarreal and his practice do not accept insurances of any kind. Checks must be made out to **Heather Clifft, LPC,** as she is the supervisor for Gabriel Villarreal. By signing below you are giving permission to Gabriel to discuss your case with Heather for supervision purposes **only**. Gabriel Villarreal is a Resident in Counseling And providing outpatient counseling services during his residency. This policy will change once Gabriel is a Licensed Professional Counselor.

____ ________________

Signature Date

I understand my medical insurance company cannot reimburse pay Gabriel Villarreal, Resident in Counseling, for his services. I agree I am responsible for all fees. Consequently, I hereby agree to pay for services rendered and for appointments not kept without 24 hours advance notice of cancellation to Gabriel Villarreal, Resident in Counseling, when the charge is incurred. There is a $35.00 return check fee. In the event of default, I promise to pay legal interest on the indebtedness, together with such collections cost and/or fees required to effect collection. I understand that my name, address, SS number, phone number, date of birth, employer name, address,and phone, date of service and charge will be released to the collection agency.

____ ________________

Signature Date

Weather Closings:

My office will notify you if the office is closed due to inclement weather. I will make every attempt to reschedule any canceled appointments as soon as possible.

Crisis:

My office is not set up to provide crisis intervention services. If you experience an emergency requiring immediate attention, please telephone the 24 hour hotline through emergency Outreach Services (540-981-9351), RESPOND at Lewis Gale Psychiatric Center (540-776-1100), or CONNECT at Roanoke Memorial Hospital (540-981-8181), or go to your nearest hospital emergency room.

If you need to speak with me directly during regular office hours (Monday - Thursday 9am - 6pm), please leave your name and telephone number with my office manager (540-772-1872). On evenings, weekends, and holidays the message will be received and acted upon during the next working day.

Any questions, and **ALL** scheduling or canceling of appointments **MUST** be directed to Mrs. Angela Dooley at 540-772-1872. She is in the office Monday - Thursday between 8:00am and 4:30pm. Angela can also be reached at angela.tcp@hotmail.com.

I, ____________________ have read, understood, and accepted the above conditions.

____ ________________

Client Signature Date

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Presenting Challenges

Chief Complaint:

What brought you to counseling?

____

____

____

How long has this challenge existed and what are the precipitating events?

____

____

____

What symptoms or impairment of functioning are you experiencing? How long?

Place a check ( ) next to the symptoms:

( ) suicidal	( ) overwhelmed	( ) dread work	( ) can't live independently
( ) agitation	( ) vomiting	( ) work absences	( ) can't keep a job
( ) fear	( ) affairs	( ) dread school	( ) can't make friends
( ) diarrhea	( ) numbness	( ) school absences	( ) can't maintain relationships
( ) headaches	( ) nightmares	( ) poor memory	( ) can't express anger
( ) nervous	( ) inferiority	( ) dread weekends	( ) substance abuse
( ) irritable	( ) indecisive	( ) money problems	( ) can't concentrate
( ) homicidal	( ) sweating	( ) sexual problems	( ) increased arguments
( ) dizzy	( ) withdrawn	( ) legal problems	( ) avoid public places
( ) fainting	( ) self harm	( ) aching joints	( ) avoid family members
( ) paranoia	( ) workaholic	( ) visual problems	( ) self deprecating thoughts
( ) insomnia	( ) can't relax	( ) stomach problems	( ) compulsive behaviors
( ) panic	( ) sadness	( ) excessive sleep.	( ) poor job performance
( ) fatigue	( ) depression	( ) avoid friends	( ) uncontrollable crying
( ) violent behavior	( ) disorganized	( ) alienate others	( ) obsessive worry
( ) blackouts	( ) hallucinations	( ) poor appetite	( ) excessive eating

( ) increased use of alcohol or other substances

What area of your life (social,family work, education) has been the most affected? How?

____

____

____

Who have you consulted about this challenge?

____

____

____

In your own words, describe your personality.

____

____

____

What are your hobbies and recreational activities?

____

____

____

Describe a typical day in your life from the time you get up until the time you go to bed at night.

____

____

____

____

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Medical History

Have you ever had any serious illnesses, convulsions, operations, hospitalizations, head trauma, or other accidents?

____

____

____

Are you currently prescribed Medications? If so please list name, dosage, and prescribing physician.

____

____

____

Substance Use

Describe your use of alcohol, cigarettes, street drugs, over the counter drugs. How much? How often? Does anyone complain?

____

____

____

Describe the same of any family members.

____

____

____

Family History

	Name	DOB	Education	Medical Health	Psychiatric Health
				(list past and present concerns and conditions)	

Self____

Mother____

Father____

Siblings____

____

____

Children____

____

____

Father's Mother____

Father's Father____

Mother's Mother____

Mother's Father____

Who presently lives in your household?

____

____

____

Have their been any changes in the management of your household in the past year? If so, in what ways?

____

____

____

Any history of verbal, physical, sexual abuse; please describe

____

____
____
____

Any other information you care to share regarding any aspect of your life?____
____
____

Gabriel Villarreal Resident in Counseling
ADHD Counseling in the Roanoke Valley

4220 Cypress Park Dr
Roanoke VA, 24018

Office: 540-772-1872
Fax: 540-772-4830

<u>CONSENT FOR RELEASE OF INFORMATION</u>

Regarding (client): ____ Date of Birth:

Address:

TO: (Names of individuals or agencies whom you authorize to release information)

____
NAME

____
ADDRESS

____
PHONE FAX

I (Client or Guardian) ______________________, hereby authorize you to release information, either verbally or in writing, from your records relevant to the case of (client) ____________________ to Gabriel Villarreal, Resident in Counseling.

Please include any psychological or physical examination, or laboratory reports, treatment summaries and discharge summaries.

Furthermore, I release the above named individuals or agencies from any legal liability resulting from the release of this information, with the understanding that reasonable professional safeguards will be taken to insure confidentiality.

This consent for release of information can be revoked at any time when the client or authorized representative request revocation in writing. This consent of release of information will expire one year from the date signed.

Client or guardian signature: ____________________________________ Date: ______

Gabriel Villarreal Resident in Counseling
ADHD Counseling in the Roanoke Valley

Disclosure Statement, Agreement For Services, and Notice of Privacy Practice

Introduction
This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents.

Information Gabriel Villarreal, Resident in Counseling
At an appropriate time, your therapist will discuss his professional background with you and provide you with information regarding his experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience, and professional orientation. Your therapist is a Resident in Counseling; he has completed all necessary hours, supervisions and has been approved by the Board of Counseling to sit for the licensing exam as soon as he chooses. As a Resident in Counseling he still has a supervisor whom he will report to weekly, Heather Clifft, LPC.

Information About This Practice (ADHD Counseling in the Roanoke Valley):
This is an individual practice, however it operates with Tanglewood Counseling and Psychology and is connected to Heather Clifft, LPC, who acts as Residency Supervisor to your therapist. Although Gabriel Villarreal, Resident in Counseling may share office space with other providers, others are not responsible for the treatment provided by Gabriel Villarreal, LPC.

Fees and Insurance
The fee for service is $100 per 50 minute individual therapy session. Payment can be made ONLY by cash or check; checks must be made to Heather Clifft, LPC (Gabriel's Residency Supervisor) due to the regulations by the Board of Counseling.

Appointment Scheduling
Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 48 hrs. in advance of your appointment. If you do not provide your therapist with at least 48 hours notice in advance, you are responsible for the full payment for the missed session.

Individual Sessions sessions are approximately 50 minutes in length. However, at certain points you and your therapist may determine that longer sessions are necessary in advance or a crisis may arise that necessitate a longer session. Fees are payable at the

time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure. Fees are reviewed annually. If my fees change at any point in the future, I will provide 60 days notice of any changes.

Your therapist does not accept insurance. Your therapist is happy to provide receipts for services so you can pursue reimbursement through your insurance company, if allowable. Please inform your therapist if you wish to utilize health insurance to pay for services, and your therapist can make appropriate referrals.

You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Please discuss any questions or concerns that you may have about this with me

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify Angela Dooley (540) 772-1872, at least 48 hrs. in advance of your appointment. If you do not provide your therapist with at least 48 hours notice in advance, you are responsible for the full payment for the missed session upon arrival of your next session.

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. (In addition, your therapist will not disclose information communicated privately to him or her by one family member, to any other family member without written permission.)

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.

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 such information. **However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. Please feel free to ask your therapist about his or her "no secrets" policy and how it may apply to you.

Social Media

If you have any questions about this policy I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

Friending:
I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Instagram, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

Interacting:
Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Instagram, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

If you need to contact me between sessions to change or cancel appointment times the best way to do so is by phone 540-772-1872. Direct email at Gabriel@RoanokeADHD.com is second best for quick clarifying questions like additional readings, resources or homework. See the email section below for more information regarding email interactions.

Business Review Sites:

You may find my psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Google, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews.

Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologists to solicit testimonials: "Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence."

Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it.

If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like.

Confidentiality means that I cannot tell people that you are my client and my Ethics Code prohibits me from requesting testimonials. But you are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provided to you, in any forum of your choosing. If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum.

If you feel I have done something harmful or unethical and you do not feel comfortable discussing it with me, you can always contact the Board of Counseling, which oversees licensing, and they will review the services I have provided: (800) 533-1560

Location-Based Services:
If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis.

Please be aware of this risk if you are intentionally "checking in," from my office or if you have a passive LBS app enabled on your phone.

Email:
I prefer using email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

INFORMED CONSENT

Minors and Confidentiality
Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his professional judgment, may 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.

Record Keeping
Your records (intake and session notes) are maintained using paper forms only. Please ask any questions or report any concerns you have regarding record keeping. As with any record keeping method, every foreseeable precaution has been taken to protect privacy, but there are no guarantees.

Therapist Availability/Emergencies
Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to lack of confidentiality of email as well as phone conversations. Through either mode of communication confidentiality cannot be guaranteed.

You may leave a message for your therapist at any time on his voicemail or with the office manager, Angela Dooley (540) 772-1872. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non urgent phone calls are returned during normal workdays (Monday through Friday) within 48 hours. Your therapist is not available to return calls after 5pm on Friday's. If you have an urgent need to speak with your

therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis:
CONNECT (540) 981-8181
RESPOND (540) 776-1100 or (800) 541-9992.

About the Therapy Process
It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist and you will also periodically exchange feedback regarding your progress.

Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy
The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Notice of Privacy Practices (If HIPAA Covered Entity)
For the Office of Gabriel Villarreal, Resident in Counseling

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. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)
I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or

condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.
However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office. You can also, request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I MAY USE AND DISCLOSE YOUR PHI
I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for other, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

1. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operation Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:
    1. For treatment. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist, I can disclose your PHI to you psychiatrist in order to coordinate your care.
    2. To obtain payment for treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
    3. For health care operations. I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professional who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I'm complying with applicable laws.
    4. Emergency disclosure. I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.
2. Certain Uses and Disclosures Do Not Require Your Consent. I can use your PHI without your consent or authorization for the following reasons:
    1. When disclosure is required by federal, state or local law; judicial or administrative proceedings; or law enforcement. For example, I may make a disclosure to applicable officials when a law requires me to report information to

government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
2. For public health activities. For example, I may have to report information about you to the county coroner.
3. For health oversight activities. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4. **To avoid Harm.** In order to avoid a serious threat to the health or safety of a person or the public, I may provide PHI to law enforcement personnel and veterans in certain situations. And I may disclose PHI for national security purposes such as protecting the President of the United States or conducting intelligence operations.
5. For specific government functions. I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
6. For workers' compensation purposes. I may provide PHI in order to comply with workers' compensation laws.
7. Appointment reminders and health related benefits or services. I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

3. 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 person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.
4. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

1. 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 disclosure your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.
2. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you at an alternative address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.
3. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you

within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

4. The Right to Get a List of the Disclosures I have Made.
1. You have the right to get a list of instances in which I have disclosed you PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family.
2. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. 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 charge, but if you make more than one based request in the same year, I will charge you a reasonable cost based fee for each additional request.
1. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that you request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.
2. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may 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. I will take no retaliatory action against you if you file a complaint about my privacy practices.

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 Gabriel Villarreal, Resident in Counseling, 4220 Cypress Park Dr, Roanoke VA 24018 or via email at Gabriel@RoanokeADHD.com

VII. EFFECTIVE DATE OF THE NOTICE

This notice went into effect on August 1st 2017.

Your signature indicates that you have read all preceding pages of this agreement for services carefully and understand its contents. Your signature also states that you have read the above privacy practices and that you have been offered a copy for your records.

Please ask your therapist to address any questions or concerns that you have about this information before you sign!

Signature of Patient(s) and Authorized Representative(s)

Date: