1650 Oregon St., ste. 102, Redding, CA 96001 Office 530.768.1031 Cell 530.227.7737 Fax 530.768.1032

Email: ron@ronbridgescounseling.com Web site www.ronbridgescounseling.com

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**Child Information/Medical History & Consent/Privacy forms** Date\_\_\_\_

Child Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_

If Someone other than the client is completing this form, please provide name and relationship to Child Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Child physical Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_ Mother's Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Biological Mom yes\_\_\_ no\_\_\_\_ Mom's address if different from child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_State\_\_\_\_ Zip\_\_\_\_\_\_ Mom's Ph. Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mom's home phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mom's Office\_\_\_\_\_\_\_\_\_\_\_\_ Mom's email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father's email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father's name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Biological Father yes\_\_\_ no\_\_\_\_\_ Father's address if different from child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip\_\_\_\_\_ Father's Cell Ph\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Father's home ph \_\_\_\_\_\_\_\_\_\_\_\_\_ Father's Office \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ph.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name and Phone of Nearest Relative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Person responsible for payment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address of responsible person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Billing and Insurance Information: How do you intend to pay for counseling services***: Cash\_\_\_\_\_\_\_\_

Check\_\_\_\_\_\_ Credit/Debit Card\_\_\_\_\_\_ Insurance\_\_\_\_\_\_ Victim Witness\_\_\_\_\_\_ 3rd Party\*\_\_\_\_\_\_\_\_\_\_\_

***\*(Fill in the following section only if a 3rd party is paying for the Counseling services for the client.***

***3rd party refers to a Parent, Sibling, Child, Relative or friend. Completion of the next three lines gives the attending Therapist permission to possibly release only necessary client information to the 3rd party for payment.***

Name of 3rd Party\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_Zip\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Primary Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child\_\_\_\_\_\_\_\_ Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-pay amount\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (It's the Parent's responsibility to discover their insurance Co-Pay. Please call Insurance prior to first visit)

***Important: Please read and sign below:***

***I, the undersigned, have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I assign my Insurance Company to directly pay Ron Bridges for all mental and behavioral health benefits assigned to me/Child. Further, if My Insurance Company determines that Ron Bridges is not on their benefits panel; I will pay Ron Bridges out of pocket for each session and will seek my own insurance reimbursement. Lastly, I understand that I am financially responsible for all charges (Including the cost of scheduled appointments I miss without the proper 24-hour notice) whether or not any or all of my Child's counseling charges are paid by my insurance company.***

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**Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***If Victim Witness***: (Please read and sign below) I, the undersigned, believe the cost for my Child’s therapy will be covered by the Victims of Crime Program in Shasta County. Ron Bridges Counseling will file the claims for the treatment provided I give him the claim number #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If I don't provide the claim number or do not qualify for the program, I understand that I am financially responsible for all charges and agree to pay Ron Bridges $ 85 per session or whatever is agreed between Ron Bridges and me. For more Information, please call Victim Witness at (530) 245-6390.

Name Of responsible Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_ **Please Notify Ron Bridges if any of the above information changes during the course of treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Day Care/Siblings/Purpose of Visit***

Does Child attend Daycare? yes\_\_\_\_ no\_\_\_\_\_. If yes, please describe daycare arrangements \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does Child have any problems associated with daycare of current living arrangements?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name and age of any other children living in the home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Concern for Seeking Therapy:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has the above been a concern?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What has been tried with your child?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Has the Child ever been in Counseling before?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

With whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the outcome?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Medical History***

Name of Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ph.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current or past major illnesses or surgeries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list and describe (if necessary) any current physical concerns \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the Child last seen by Physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Physical exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Current medications**

**Medication Purpose Prescribing Doctor**

1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Complaints and/or Concerns*** *(Please check all that apply)*

Fearful\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stuttering\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School issues\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bed wetting\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drug Use\_\_\_\_\_\_\_\_ Name? \_\_\_\_\_\_\_\_ Daydreaming\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Soiled pants\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Withdrawn\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleeping problems\_\_\_\_\_\_\_\_\_\_ Victim of Abuse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Temper tantrums\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nightmares\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of abuse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Irritable\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleeps with light on\_\_\_\_\_\_\_\_\_ Suicide talk\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Slow\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleeps with parent(s) \_\_\_\_\_\_\_\_ Rocking or tics\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Overactive\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mean to others\_\_\_\_\_\_\_\_\_\_\_\_\_ Self-mutilating\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Trouble sharing with others\_\_\_\_\_\_\_\_

Lying\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nail biting\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sad or depressed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Destructive to property\_\_\_\_\_\_\_ Head banging\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alcohol use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Infantile\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Running away\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ lacks initiative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fire setting\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stealing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Easily distractible\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hits others at school\_\_\_\_\_\_\_\_\_ Disobedient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unusual behavior\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Learning problems\_\_\_\_\_\_\_\_\_\_ Impulsive\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unusual thoughts\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doesn't sit still\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sexual issues\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hums to self\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Short attention span\_\_\_\_\_\_\_\_\_ Social relationships\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ other notable \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any current suicidal thoughts yes\_\_\_\_\_\_ no\_\_\_\_\_\_ Did child tell you or did you ask? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any previous suicide attempts? Yes\_\_\_\_\_ no \_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_ Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has the Child witnessed any specific family traumatic event? Yes\_\_\_\_\_ no \_\_\_\_\_\_. If yes, please share the event with the therapist prior to therapy, if possible.

Any Religious affiliation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the Child currently attend any Church mid-week function? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the Child encouraged to attend church or church functions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are both parents involved with the child's church involvement yes\_\_\_\_\_\_ no\_\_\_\_\_\_ one parent? \_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Family History***

Is there any mental illness in the biological parents of the child? yes\_\_\_\_ no\_\_\_\_ if yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are there any confirmed alcoholic family members? Yes\_\_\_\_ no \_\_\_\_ If yes, please list family member\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Present Significant Relationship of Attending Parent*** (Check which applies)

Single\_\_\_\_\_\_ How Long\_\_\_\_\_\_\_ Separated\_\_\_\_\_\_ How Long \_\_\_\_\_\_Divorced\_\_\_\_\_\_\_ How Long\_\_\_\_\_

**(Please turn page over)**

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Married\_\_\_\_\_\_ How Long\_\_\_\_\_\_ Divorced\_\_\_\_\_\_ How Long\_\_\_\_\_\_ Engaged\_\_\_\_\_ How long\_\_\_\_ Widowed\_\_\_\_\_ How Long\_\_\_\_ Committed Relationship\_\_\_\_ How Long\_\_\_\_ Remarried\_\_\_\_ How long\_\_\_\_ If previous marriages, How many?\_\_\_\_ First name(s) of spouse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Names and Ages of Children from Previous marriages/Relationships\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Names and Ages of Present Children living in home***

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_

Any additional relevant information you would like us to know about your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Please review and sign the following informed consent & read Privacy Practice***

***Informed Consent***

*Welcome to the Counseling office of Ronald F. Bridges. It will be my privilege to invest my training, experience, and heart into your world in order to encourage your life, your marriage your family or your past towards discovery, healing and growth. It will be my commitment to develop a genuine and compassionate relationship towards earning your trust. But I will also be honest and direct when such times may be necessary. The therapeutic process may be difficult at times, but if entered into with a genuine goal to improve your condition, then the process is worth it. Let's start your journey together.*

***Confidentiality***

It is my commitment to you that all information shared in sessions will be strictly confidential. The only exceptions are:

* Suspected Child Abuse, Elder Abuse, Dependant Adult Abuse, Neglect, or Emotional Abuse.
* A serious threat to harm yourself or others.
* Your Insurance Company paying for your service has the right to review your records.
* You waive your right to privilege and give consent to limited disclosure of information to a

Specific person for a specific time frame.

* I am ordered by a Judge of the Court in a legal proceeding.
* I am appointed by the Court to evaluate you.

***Appointments/Cancellations*** Page 5

We usually make appointments over the phone. Call my office and leave a message and I will return it within 24 hours. I am usually in session most all afternoons and sometimes unable to make calls until after 7 pm. We can set appointment times, discuss my therapeutic orientations and discuss costs and means of payment at that time. If it is your first visit, please come with the Counseling forms downloaded off my web site filled out with your signatures. This will save much time. Additionally, when you arrive at our location please find our comfortable waiting area (suite 102) and relax. I will usually be in session when you arrive, but I will come out to welcome you on the hour. At end of our session, I have a rear exit door for your exit in case you are feeling emotionally private with your thoughts.

Many of my existing clients enjoy the convenience of texting me for appointments. But, I cannot make an appointment by text for our first meeting. I am usually not available on weekends or Monday's, but emergencies are a priority regardless of what day they occur. In the event of vacation or conferences, another therapist will be covering for me. If you arrive more than 15 minutes late for a session, you will still be billed in full for that session. The hour has been committed to you so please give yourself the benefit of the full time frame and be on time.

**Cancellation Policy: Appointments that are not cancelled within 24 hours in advance will be charged the rate of the session. You are responsible for late cancels and no-shows. Insurance companies and Victim Witness will not reimburse you or me for missed appointments. You will be charged directly.**

***Payment, Fees and Insurance Billing (Next page)*** Payment of counseling services are expected by cash, check or debit/credit card. Currently, we take

Visa, Master Charge and Discover. Checks should be written out to Ron Bridges Counseling, or just Ron Bridges. Additionally, payment is best received at the beginning of our time together, as the end of our session will often provoke teachable thoughts that might be distracted if interrupted with payment transactions.

Further, please know there will be a $ 30.00 charge for all returned checks and, if for reasons of non-payment your account goes to collections, there will be a 25% fee added to your balance for the cost of collections. Fees are as follows and are subject to change;

***FEE SCHEDULE***

**Session Time Frame Cost per Session**

Individual or Couples therapy........................... 50 minutes................................................ $ 75.00

Two hour Individual or Couples....................... 100 minutes .............................................$ 150.00

Group Therapy.......................................................... 50 minutes............................................... $ 35.00

Emergency Sessions................................................ 55 minutes ..............................................$ 150.00

Report writing...................................................................................................................................$150.00 per hour

Court appearances (including subpoenas)...........................................................................$ 100.00 per hour

**(Please note: All Court Appearances paid upon arrival)** $ 350.00 per half day

$ 700.00 per full day

Appointment phone calls.......................................Brief...........................................................$ No Charge

Consultation or Collaboration............................Up to 10 minutes...................................$ No Charge/$20 after

Crisis Calls......................................................................As needed..............................................$ $20/10 minutes

***Sliding Fee Schedule*** Page 6

Yes, I do have a sliding fee policy. Such a policy is in place for the needy. It will be discussed and applied on a case-by-case basis and it is not to be considered as a lengthy solution.

***INSURANCE BILLING***

Please authorize your Insurance Company to directly pay Ron Bridges Counseling for counseling services rendered to you**. It is also your responsibility to contact your insurance company to ascertain the co-payment fee, if any, and to determine if I am approved as a preferred provider on their provider insurance panel.** I have applied for preferred provider status with many different insurance companies, but it is often a lengthy process for approval and I may not have received approval yet with your particular company. If I am not, I am considered an out-of-area provider which means you are most likely responsible to **pay the fee in full at the time of our sessions** and then seek your own reimbursement with your insurance company.

**Please sign below indicating** **your understanding and agreement with this contract, including the cancellation policy and the above fees. Additionally, please acknowledge downloading and/or receiving our Notice of Privacy Practices.**

Primary Client Signiture\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Best Phone Number to reach you:***  Cell/Home/Office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Privacy Practices**

**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.**

I am required by law to maintain the privacy and security of your protected health information (PHI) and to provide you with this Notice of Privacy Practices (Notice). I must abide by the terms of this Notice , and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization (Authorization). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

**Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent.** I can use and disclose your PHI without your authorization for the following reason: **1) For Your Treatment.** I can use and disclose your PHI to another Health Care Professional. For example, if you are being treated by a physician or psychiatrist, I can disclose your PHI to him or her to help coordinate your care,

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although my preference is for you to give me an Authorization to do so. **2) To obtain payment for your 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 to get paid for the health care services I have provided to you, although my preference is for you to give me an authorization to do so. **3). For Health Care Operations.** I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

**Certain Uses and Disclosures Require Your Authorization. 1) For Psychotherapy Notes.** I do keep "psychotherapy notes" as the term is defined in 45 CFR € 164.501, and any use or disclosure of such notes requires your authorization unless the use or disclosure is: **a. For my use in treating you; b. For my use in training or supervising other mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy; c. For my use in defending myself in legal proceedings instituted by you; d. For use by the Secretary of health and Human Services to investigate my compliance with HIPAA; e. Required by law, and the use or disclosure is limited to the requirements of such law; f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes; g. Required by a coroner who is performing duties authorized by law; h. Required to help avert a serious threat to the health and safety of others. 2) Marketing Purposes.** As a psychotherapist, I will not use or disclose your PHI for marketing purposes. **3) Sale of PHI.** As a psychotherapist, I will not sell your PHI in the regular course of my business.

**Certain Uses and Disclosures Do Not Require Your Authorization.** Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons: **1)** When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law. **2)** For public health activities, including reporting suspected child, elder or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety. **3)** For health oversight activities, including audits and investigations. **4)** For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so. **5)** For law enforcement purposes, including reporting crimes occurring on my premises.  **6)** To coroners or medical examiners, when such individuals are performing duties authorized by law. **7)** For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition. **8)** Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions. **9)** For workers' compensation purposes. Although my preference is to obtain an authorization from you. I may provide your PHI in order to comply with workers' compensation laws. **10)** Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

**Certain Uses and Disclosures require you to have the Opportunity to Object.**

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**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.

**Your Rights 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 me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care. **2) The Right to Request Restrictions for Out-Of-Pocket Expenses Paid for in Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full. **3) The Right to Choose How I send PHI to you.**  You have the right to ask me to contact you in a specific way (for example, home or office or office phone) or to send mail to a different address, and I will agree to all reasonable requests. **4) The Right to See and Get Copies of Your PHI.** Other than "psychotherapy notes" you have the right to get an electronic or paper copy of your medical records and other information that I have about you.

I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I will charge a reasonable, cost-based fee for doing so. Cost for a copy of the records (other than psychotherapy notes) shall be $**10.00.** If your request is for a written summary, the charge will be **$ 40.00.**

**HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES…..**

If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice, and my address and my phone number is: 1650 Oregon St. ste. 102, Redding, CA 96001 Ph. (530) 768-1031.

You may also file a complaint with the U.S. Department of Health and Human Services office for Civil Rights by:

1) Sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201.

2) Calling 1-877-696-6775. Or,

3) Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

I will not retaliate against you if you file a complaint about my privacy practices.

**EFFECTIVE DATE OF THIS NOTICE:**

**This notice went into effect on \_\_\_\_\_\_\_September 20, 2013\_\_\_\_\_\_And this shall remain in effect until it is replaced.**