DONNA MCLEMORE WATKINS, MEd, LPC, RPT
INFORMED WRITTEN CONSENT FOR TREATMENT POLICY STATEMENT FORM

Thank you for selecting me as your counselor. The intent of this statement is to inform you about the basic therapeutic relationship between counselor and client, to inform you of basic policies, and to help you understand our professional relationship.

Counseling Philosophy, Expectations of Clients

I believe in the capacity of people for self-efficacy. This means that you are able to personally create an improved quality of life and you are in charge of your goals and personal growth. I will work with you in achieving these personal goals. My approach to therapy involves mind, body, and spirit through the use of evidence-based practices. We will together examine issues related to your self-relationship and relationships with others.

Your decision to choose to enter counseling is a voluntary one and you may terminate at any time. If, in my professional opinion, it is in your best interest to refer you to another therapist, I will do so because of ethical standards. I will provide you with the contact information of the referral. Please note that it is impossible to guarantee any specific results regarding your counseling goals; however, we will work together to achieve the best possible results. At the end of the first session, we will decide if we want to enter into a counseling relationship. If we both agree, you will sign, date, and keep a copy of this informed consent.

Scope of Practice

I operate in an outpatient private practice consisting of traditional talk therapy, equine therapy, and other experiential therapies. I work with children, adolescents, and adults. I cannot and do not assume responsibility for client's daily functioning as an institution can. I am not an emergency facility for crisis management. I make every effort to return phone calls during office hours as quickly as possible but there may be unavoidable delays. I can be reached at 770-947-2311. IN THE EVENT OF AN EMERGENCY, you should call 911 or go to the emergency room.

Ethical Guidelines and Standards

I assure you that my services will be provided in a professional manner consistent with accepted ethical standards for licensed professional counselors.

Confidentiality

Please understand that I will keep confidential what you disclose, with the following exceptions:

1. You direct/allow me to tell someone by signing a release of information form.
2. I determine you are a danger to yourself or others.
3. I am ordered by a court to disclose information
4. You abuse a child or an elderly person.

Your signature indicates that you have reviewed this document, had your questions answered to your satisfaction and you agree to adhere to policies specified in this document.

_____ _____

Printed Name Date

_____ _____

Client Signature

Guardian Signature for minor clients

Today's Date: _____

Red Clay Counseling, LLC
Patient Information and Financial Agreement

(Please Print Legibly)

PATIENT INFORMATION

Please use full legal name (no nicknames please)

Last _____ First _____ MI _____
DOB _____Age _____M/F _____SSN _____
Physical Address _____
Mailing Address _____
City _____State _____ Zip _____
County _____
Cell/Home Phone _____ E-Mail _____

PARENT/GUARDIAN (Person responsible for care and financial situations)

Last _____ First _____ MI _____
DOB _____ SSN _____ Occupation _____
Mailing Address _____
Primary Phone _____Secondary _____
Employer _____Work Phone _____
E-mail _____
Other parent/guardian _____Phone _____

Are parents separated or divorced? Yes _____ No _____
If you are not a parent, are you the legal guardian? Yes _____ No _____
Best number to confirm your appointment? _____
YOU WILL NEED TO SHOW PROOF OF CUSTODY OR GUARDIANSHIP

ADDITIONAL INFORMATION

Referring Physician or Psychiatrist (Please provide doctors full name)
Phone# Diagnosis _____
If patient has seen other mental health professionals, please include psychians name and diagnosis_____

INSURANCE INFORMATION (Please fill out completely)

Primary Insurance name _____
Insurance ID#_____
Policy Holder's Name DOB _____
SSN _____ Relation to Patient _____
Group Number _____ Employer _____
Secondary Insurance Name _____ Insurance ID# _____
Policy Holder's Name _____ DOB _____
SSN _____ Relation to Patient _____
Group Number _____ Employer_____

INSURANCE AUTHORIZATION AND ASSIGNMENT
(Please Read and Initial=lnit. each section)

Init._____ I request that all insurance benefits be paid directly to Red Clay Counseling, LLC.

Init._____You are entitled to a clear understanding of your financial obligations before services are rendered. We participate with numerous managed care plans and to the best of our ability, certify your benefits prior to being seen. It is not possible for us to know all of the individual requirements of each plan. Your employer negotiates the benefits of your plan and we have no control over how claims may or may not be processed. Each plan is different in regards to what is covered, how often and where services may be rendered. Whether you have insurance or are self-pay, we maintain that you are ultimately responsible for all charges incurred.

Init. _____ We do not file indemnity plans, non-contracted or secondary insurance carriers. We try to assist you in getting services covered; but are not responsible if they are not covered under your contract and you will be billed. It is your responsibility to ensure that a referral and/or authorization has been obtained if necessary. If we do not have a referral on file, we are happy to see you as a self-pay patient. For a self-pay patient, full payment is required at the time of service.

Init. _____ If insurance cannot be verified by date of service, we expect payment in full. We accept cash, check and credit cards. If you do not have insurance, we expect payment in full, unless prior arrangements have been made with the business office.
***Co-pays are due at time of service; if it is not paid at the time of service, we will bill you with an additional administrative fee of 15% per visit.

***There is a per page fee for any written communication, to be paid at time of completion. Once requested, this fee will apply whether you choose to utilize it or not.

***Please make all checks payable to Red Clay Counseling, LLC.

*** We charge a $35.00 returned check fee.

***__Cancellation fees and NO SHOW fees__: $65.00 -individual therapy; $70.00-family therapy, or amount equivalent to reserved time for cancellation with less than 24 hours notice.

***No-show fees are billed to you directly and are your responsibility. Insurance will not pay.

***Medical records can be obtained with signed release and applicable administrative fees at time of release. There is a fee incurred.

***This office practices Credit Bureau reporting for all delinquent balances.

*** **Court Appearance:** If Red Clay Counseling, LLC, Donna M. Watkins, M.Ed., LPC, testifies in court or is subpoenaed, client will pay $150.00 per hour of time, including, but not limited to, preparation for court, testifying, and will include time at courthouse to appear. If to be paid by another entity besides client and entity does not pay, client is responsible for full amount.

Init._____ I acknowledge understanding for above.

I have read, understand and accept the terms of this financial policy. I have been provided a copy of the Privacy Practices Notice.

Date _____
Responsible Party or Patient/Client Signature _____
Printed Name _____
Signature of Staff/Witness _____

Red Clay Counseling, LLC

Patient Confidentiality

We request all cell phones and electronic devices be turned off during sessions for further patient confidentiality. Absolutely no videotaping or recording allowed to insure patient confidentiality.

Patient confidentiality is a top priority at Red Clay Counseling, LLC. Therefore, it is important that you provide us with the following information to ensure that there is no violation of your privacy.

I acknowledge that I have been made aware of the "NOTICE OF PRIVACY PRACTICES" for Protected Health Information on the date set forth below.

In the event that I am unable to be reached, Red Clay Counseling, LLC may leave any appointment or account information in the following manner:

_____ You may leave messages on my mobile phone. Number: _____

_____ You may leave messages on my home answering machine. Number: _____

_____ You may call my work number and leave a message. Number:_____

_____ You may leave messages on my office voicemail. Number: _____

_____You may share appointment/account information with my spouse. Number: _____

_____ You may share appointment information with my children. Number: _____

_____ You may share my appointment and account information with:

Name _____ Phone Number _____ Relationship to Patient _____

Name _____ Phone Number _____Relationship to Patient _____

_____ In the event you are unable to reach me; Red Clay Counseling **may not** leave appointment information or account information with anyone but myself, including on voicemail, at the following phone number: _____

Proxy Permission Form: The following person(s) may make medical decisions and sign any appropriate documents related to my child's care in my absence.

Name of Proxy (Please print) Relationship

_____

Signature of Client or Guardian Date Relationship to Client

_____

Red Clay Counseling, LLC Medical Release

Date of Release_____

Name_____ DOB (mm/dd/yyyy)_____

Address_____

Phone Number ( )_____

I give Red Clay Counseling, LLC permission to contact the following person in case of a medical emergency:

Name_____

Phone Number ( )_____

Additionally, I give permission for Red Clay Counseling, LLC staff to contact 911 and/or emergency personnel to assist in the case of an emergency.

Please Note: Please take care when entering & exiting the property by driving slowly into the parking area, watching out for children, other cars or loose animals. Also, while taking the stairs up and down into the center, hold the hand rails and step carefully. Please hold on to small children and monitor them, while inside and outside the building to ensure that they do not exit. Parents/guardians will accompany all children under age of 10 to the downstairs restroom.

Signature of Client or Guardian:_____ Date:_____

Signature of Staff/Witness:_____ Date:_____

Red Clay Counseling, LLC
Donna M. Watkins, M.Ed., LPC

Welcome,

These are a few friendly reminders about OAKHILL and Red Clay Counseling, LLC:

*Because parking is limited, please park in the marked parking area.

*Since the waiting area is small, **please limit persons who accompany the patient being seen.**

*This is a totally, non-smoking facility, including smoking in vehicles on the property.

*Please do not bring food or drinks inside the building.

*Please do not leave your children unattended.

*Please assist little ones under the age of 6 going up and down the stairs.

*Please accompany children under the age of 10 to the restroom, located downstairs.

*Please do not wander the property without staff escort.

*Please do not feed or touch the animals without staff guidance.

*Please inform Red Clay Counseling, LLC of cancellations within 24 hours to avoid a No Show Charge.

We appreciate your understanding and respect for this sacred space.

Sincerely,

Donna M. Watkins, M.Ed., LPC

Red Clay Counseling, LLC

I, _____, have read, understand and accept the terms of the
(printed name of client or guardian if minor)

general rules and guidelines at Red Clay Counseling, LLC and Douglasville Psychotherapy Center at Oakhill, P.C. I have been provided a copy of the Rules in the new client forms package.

Date: _____

Responsible Party or Patient/Client Signature: _____

Printed Name: _____

Signature of Staff/Witness: _____

Red Clay Counseling, LLC

CHILD PSYCHOSOCIAL (Ages 3-11 years)

IDENTIFYING INFORMATION

Date of Initial Appointment _____

Name of child _____ Sex _____

Birthdate _____ Place of birth _____ Age _____

Address (number and street) _____

City _____ State _____ Zip _____

Telephone _____ Religion (optional) _____

Education (grade) _____ Present school _____

Referral Source _____

Adult completing form _____ Relationship _____

CHIEF COMPLAINT

Presenting Problems (check all that apply)

_____Very unhappy	_____Impulsive	_____Fire setting	_____Irritable
_____Stubborn	_____Stealing	_____Temper outbursts	
_____Disobedient	_____Lying	_____Withdrawn	_____Infantile
_____Sexual trouble	_____Daydreaming	_____Mean to others	
_____School performance	_____Fearful	_____Destructive	_____Truancy
_____Clumsy	_____Bed wetting	_____Trouble with the law	
_____Overactive	_____Running away	_____Soiled pants	_____Slow
_____Self-mutilating	_____Distractible	_____Rocking	_____Eating problems
_____Sickly	_____Lacks initiative	_____Shy	_____Drug use
_____Undependable	_____Alcohol use	_____Strange behavior	_____Peer conflict
_____Strange thoughts	_____Suicide talk	_____Aggressive toward others	

How long have these problems occurred? (Number of weeks, months, years) _____

_____

What happened that makes you seek help at this time? _____

_____

Problems perceived to be: Very serious _____ Serious _____ Not serious _____

What are your expectations of your child? _____

What changes would you like to see in your child? _____

_____

What changes would you like to see in yourself? _____

_____

What changes would you like to see in your family? _____

_____

PSYCHOSOCIAL HISTORY

Current Family Situation

Biological Mother's Name: _____ Age: _____

Stepmother's Name: _____Age: _____

Adoptive Mother's Name: _____Age: _____

Biological Father's Name: _____ Age: _____

Stepfather's Name: _____Age: _____

Adoptive Father's Name: _____ Age: _____

MARITAL HISTORY OF PARENTS

Natural Parents:	_____Married	When _____	Ages _____, _____
	_____Separated	When _____	
	_____Divorced	When _____	
	_____Deceased	When _____	M or F _____
Step Parents	_____Married	When _____	
	_____Separated	When _____	
	_____Divorced	When _____	

If Child is Adopted:

Adoptive Source _____

Reason and circumstances _____

Age when child first came into home _____

Date of legal adoption _____

What has the child been told _____

LIVING ARRANGEMENTS

Number of moves in child's life _____

Places and Dates _____

_____

Present Home (Renting or Buying) _____

Apartment or House _____

Does the child share a room with anyone else _____ If no, how long has child had own space _____

Was the child ever places, boarded or lived away from the family _____

Explain _____

What are the major family stressors at the present time, if any _____

_____

What are the sources of family income _____

_____

List All Individuals Living In the Home:

Name Relationship Age Sex School Present grade Living at home Uses Drugs

_____

_____

_____

_____

_____

HEALTH OF FAMILY MEMBERS

List other extended family members by their relationship to the patient and/if they have drug and/or alcohol problems (legal or illegal), history of depression, self-destructive behavior, or legal problems.

Name: _____ Relationship: _____Type of Issue:_____

Name: _____ Relationship: _____Type of Issue:_____

Name: _____ Relationship: _____Type of Issue:_____

Does or did any member of the child's family have any problems with: _____Reading _____Spelling _____Math _____Speech

If yes, explain _____

Is there any history in the child's family of:

_____Mental retardation _____Epilepsy _____Birth defects _____Schizophrenia

If yes, explain _____

CHILD HEALTH INFORMATION

Note all health problems the child has had or has now

Symptom	Age	Symptom	Age
_____High fever	_____	_____Dental problems	_____
_____Pneumonia	_____	_____Weight problems	_____
_____Flu	_____	_____Allergies	_____
_____Encephalitis	_____	_____Skin problems	_____
_____Meningitis	_____	_____Asthma	_____
_____Convulsions	_____	_____Headaches	_____
_____Unconsciousness	_____	_____Stomach problems	_____
_____Concussions	_____	_____Accident prone	_____
_____Head injury	_____	_____Anemia	_____
_____Fainting	_____	_____High or low blood pressure	_____
_____Dizziness	_____	_____Sinus problems	_____
_____Tonsils out	_____	_____Heart problems	_____
_____Vision problems	_____	_____Hyperactivity	_____
_____Hearing problems	_____	_____Earaches	_____
_____Other problems	_____		

Explain _____

_____

Has the child ever been hospitalized? Yes _____ No _____

If yes, when and for how long _____

_____

Has the child ever been seen by a medical specialist? Yes _____ No _____

If yes, explain _____

_____

Has the child ever taken or is he/she currently taking any prescribed medications? Yes _____ No _____

If yes, explain _____

_____

Name of Primary Care Physician _____

DEVELOPMENTAL HISTORY

Pregnancy/Child Wanted? Yes _____ No _____ Planned for? Yes _____ No _____

Normal pregnancy? Yes _____ No_____

Was mother ill during pregnancy? Yes _____ No _____ Explain _____

_____

Length of pregnancy _____ Parental support and acceptance _____

BIRTH

Length of active labor _____ Easy _____ Difficult _____

Full term? Yes _____ No _____ If premature, how early _____

If overdue, how long _____

Birth weight _____ Type of delivery _____ Head first _____ Breech _____

Was is necessary to give the infant oxygen? Yes _____ No _____ For how long _____

Did the infant require blood transfusions? Yes _____ No _____

Did the infant require X-rays? Yes _____ No _____

Physical condition of infant at birth _____

Did the mother abuse alcohol/drugs during pregnancy? Yes _____ No _____ For how long _____

Did the mother use tobacco during pregnancy? Yes _____ No _____ For how long _____

NEWBORN PERIOD

Symptom	Yes	No
Irritability	_____	_____
Vomiting	_____	_____
Difficulty breathing	_____	_____
Difficulty sleeping	_____	_____
Convulsions/twitching	_____	_____
Colic	_____	_____
Normal weight gain	_____	_____
Was child breast fed	_____	_____

DEVELOPMENTAL MILESTONES

Age at which the child:

Sat up _____

Crawled _____

Walked _____

Spoke single words _____

Sentences _____

Bladder trained _____
Bowel trained _____
Weaned _____

Describe the manner in which toilet training was accomplished _____

_____

EARLY SOCIAL DEVELOPMENT
Relationship to siblings and peers

_____Individual play _____Group play
_____Competitive _____Cooperative
_____Leadership role _____A follower

Describe special habits, fears, or idiosyncrasies of the child _____

_____

Educational History

	Name	City/State	Dates attended	Grade completed
Preschool				
Elementary				
Junior High				
High School				

Type of classes? Regular _____ Learning Disability _____ Continuation _____
Emotionally Handicapped _____ Opportunity _____
Did the child skip grades? Yes _____ No _____ Which grade _____
Did the child repeat a grade? Yes _____ No _____ Which grade _____
Does the child have specific learning disabilities? _____
Has the child ever had a tutor or other special help with school? _____
Does the child attend school on a regular basis? Yes _____ No _____
Does the child appear motivated for school? Yes _____ No _____
Has the child ever been suspended or expelled? Yes _____ No _____

RECREATIONAL:
How does your child spend his/her time?

_____

_____

What hobbies does your child enjoy?

_____

How often does your child play:

By himself or herself? _____

With his/her friends?_____

With family? _____

What was the most fun your child has ever had?

_____

When was your child happiest?

_____

What type of physical activity is your child involved in?

_____

What activities do you do with your child?_____

_____

TREATMENT GOALS:

In looking at your child's current situation, in what areas would you like to see improvement? Please check all that apply and add more if needed.

____Anger Control	____Stress Management	____Fair Fighting
____Communication Skills	____Problem Solving	____Parenting
____Increasing Flexibility	____Assertiveness Skills	____Decision Making
____Socially Comfortable	____Financial Management	____Self Esteem

Any additional treatment goals for your child:

_____

_____

_____

ACADEMIC PERFORMANCE

Highest grade on last report card _____
Lowest grade on last report card _____
Favorite subject _____
Least favorite subject _____
Does child participate in extracurricular activities? Yes _____ No _____ Which ones _____
_____

In school, how many friends does the child have? _____

What are the child's educational aspirations? _____

Has the child had special testing in school? Yes _____ No _____ Explain _____
_____

List the child's special interests hobbies, skills

_____
_____

_____

Has the child ever had difficulty with the police? Yes _____ No _____ When _____

Has the child ever appeared in juvenile court? Yes _____ No _____ When _____

Has the child ever been on probation? Yes _____ No _____ When and for how long _____
_____

Has the child ever been employed? Yes _____ No _____ Where and for how long _____
_____

CULTURAL CONSIDERATIONS

_____
_____
_____

ADDITIONAL COMMENTS

_____
_____
_____
_____

(If able, for Child to complete. Caregiver may read to child, have child complete sentence, and caregiver may write sentences.)

Sentence Completion

Date _____

Child's Name _____

I would like to _____

Tomorrow I will _____

My mother _____

I cannot _____

I wish that I _____

If I only _____

I worry about _____

Girls _____

I am ashamed _____

I am afraid _____

I hope _____

My father _____

I like _____

I don't like _____

In school I _____

I love _____

Boys _____

It isn't nice to _____

A mother should _____

My teacher _____

There are times when _____

I hate _____

Caregiver's Questionnaire

Date _____

Name of child _____ Age _____

Name of caregiver (completing form) _____

Answer all of the questions by indicating the degree of the problem. Write" N" for never, "S" for sometimes, or "O" for often in front of the number for each question.

Questions

_____ 1. Picks at things (nails, fingers, hair, clothing)

_____ 2. Talks back to authority figures (attitude)

_____ 3. Has problems with making or keeping friends

_____ 4. Excitable, impulsive

_____ 5. Wants to run things

_____ 6. Sucks or chews (thumbs, clothing, blankets, etc)

_____ 7. Cries easily/often

_____ 8. Emotionally reactive

_____ 9. Has a chip on his/her shoulder

____ 10. Tendency to daydream

____ 11. Always squirming, restless, and moving around

____ 12. Difficulty learning

____ 13. Experiences fear and anxiety in new situations/meeting new people

____ 14. Breaks things/destructive

____15. Lies, makes up stories

____ 16. Does not follow the rules

____ 17. Gets into trouble more than peers

____ 18. Shy and does not assert self

____ 19. Has problems with speech (stuttering, hard to understand baby talk)

____ 20. Denies mistakes and is defensive

____ 21. Blames others for mistakes

____ 22. Steals

____ 23. Argumentative

____ 24. Disrespectful

____ 25. Pouts and sulks

____ 26. Obeys rules but is resentful

____ 27. When hurt or angered by someone, holds a grudge

____ 28. Develops stomach-ache or head-ache when stressed

____ 29. Worries unnecessarily

____ 30. Does not finish tasks

____ 31. Emotionally sensitive and easily hurt

____ 32. Bullies others

____ 33. Cruel and insensitive

____ 34. Clingy and in need of constant reassurance

____ 35. Easily distracted

____ 36. Frequent head-aches or stomach-aches

____ 37. Rapid mood changes

____ 38. Fights a lot and creates conflicts

____ 39. Power struggles with authority

____ 40. Childish or immature and wants help when should be able to do it independently

____ 41. Does not get along well with siblings

____ 42. Easily frustrated

____ 43. Perfectionism prevents trying new things

____ 44. Problems with sleep

____ 45. Problems with eating

____ 46. Has bowel problems

____ 47. Vomiting, nausea, or other complaints of pain or physical distress

____ 48. Feeling he/she is treated differently in the family than siblings

____ 49. Passive and gets pushed around

____ 50. Self-centered, brags, little understanding of others

HIPAA Notice of Privacy Practices Statement

Red Clay Counseling, LLC

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

All information describing your mental health treatment and related health care services ("mental health information") is personal, and we are committed to protecting the privacy of the personal and mental health information you disclose to us. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. When we disclose information to other persons and companies to perform services for us, we require them to protect your privacy too. This Notice applies to your counselor, psychotherapist, psychiatrist and other health care professionals who provide care to you. We must also provide certain protections for information related to your medical diagnosis and treatment, including HIV/AIDs, and information about alcohol and other substance abuse. We are required to give you this Notice about our privacy practices, your rights and our legal responsibilities.

WE MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION:

For TREATMENT for example, we may give information about your psychological condition to other health care providers to facilitate your treatment, referrals or consultations.

For PAYMENT for example, we may contact your insurer to verify what benefits you are eligible for, to obtain prior authorization, and to receive payment from your insurance carrier.

For APPOINTMENTS AND SERVICES to remind you of an appointment, or tell you about treatment alternatives or health related benefits or services.

WITH YOUR WRITTEN AUTHORIZATION we may use or disclose mental health information for purposes not described in this Notice only with your written authorization.

WE MAY USE YOUR MENTAL HEALTH INFORMATION FOR OTHER PURPOSES WITHOUT YOUR WRITTEN AUTHORIZATION.

As REQUIRED BY LAW when required or authorized by other laws, such as the reporting of child abuse, elder abuse or dependent adult abuse.

For HEALTH OVERSIGHT ACTIVITIES to governmental, licensing, auditing and accrediting agencies as authorized or required by law including audits; civil, administrative or criminal investigations; licensure or disciplinary actions; and monitoring of compliance with law.

In JUDICIAL PROCEEDINGS in response to court/ administrative orders, subpoenas, discovery requests or other legal process.

To PUBLIC HEALTH AUTHORITIES to prevent or control communicable disease, injury or disability, or ensure the safety of drugs and medical devices.

To LAW ENFORCEMENT for example, to assist in an involuntary hospitalization process.

To THE STATE LEGISLATIVE SENATE OR ASSEMBLY RULES COMMITTEES for legislative investigations.

For RESEARCH PURPOSES subject to a special review process and the confidentiality requirements of state and federal law.

To PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY of an individual. We may notify the person, tell someone who could prevent the harm, or tell law enforcement officials.

To PROTECT CERTAIN ELECTIVE OFFICERS including the President, by notifying law enforcement officers of potential harm.

YOU HAVE THE FOLLOWING RIGHTS:

To Receive a Copy of this Notice when you obtain care.

To Request Restrictions. You have the right to request a restriction or limitation on the mental health information we disclose about you for treatment, payment or health care operations. You must put your request in writing. We are not required to agree with your request. If we do agree with the request, we will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment.

To Inspect and Request a Copy of Your Mental Health Record except in limited circumstances. A fee will be charged to copy your record. You must put your request for a copy of your records in writing. If you are denied access to your mental health record for certain reasons, we will tell you why and what your rights are to challenge that denial.

To Request an Amendment and/or Addendum to your Mental Health Record. If you believe that information is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record) of no longer than 250 words for each inaccuracy. Your request for

amendment and/or addendum must be in writing and give a reason of the request. We may deny your request for an amendment if the information was not created by us, is not a part of the information which you would be permitted to inspect and copy, or if the information is already accurate and complete. Even if we accept your request, we do not delete any information already in your records.

To Receive An Accounting of Certain Disclosures we have made of your mental health information. You must put your request for an accounting in writing.

To Request that We Contact you by Alternate Means (e.g., fax versus mail) or at alternate locations. Your request must be in writing, and we must honor reasonable requests.

CHANGES TO THIS NOTICE. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for information we already have about you as well as any information we receive in the future.

CONTACT INFORMATION:

If you have questions about this Notice or believe your privacy rights have been violated, you may contact:

The Secretary of the Department of Health and Human Services
Contact the Office for Civil Rights
1-866-627-7748, 1-800-537-7697 (TTY)
http://www.hhs.gov/ocr/privacy/hipaa/complaints/
Filing a complaint will not affect the services you receive at Red Clay Counseling, LLC.

By law, Red Clay Counseling, LLC is required to follow the terms in this privacy notice. Red Clay Counseling, LLC has the right to change the way your personal health information is used and given out. If Red Clay Counseling, LLC makes any changes to the way your personal health information is used and given out while you are a current client, you will get a new notice, directly or by mail, within 60 days of the change.