Adult Client Paperwork Instructions

Print the paperwork below, fill it out and bring it to your appointment. You may fax it prior to your appointment. Fax #: (757) 490-6995
***If you are being seen for couples counseling both of you will need to fill out a packet.

If you are not able to fill out the paperwork please arrive 30 minutes early to fill it out in the office.

For all appointments in our VIRGINIA BEACH office during the day (9am-5pm) please arrive 10 minutes early for check-in.

For questions regarding the attached paperwork, directions, or insurance please contact us at (757) 490-6960.

If unable to make this scheduled appointment, please call as soon as possible to reschedule.

We look forward to meeting you!
SECTION 1: CLIENT INFORMATION

Today’s Date: __________________________

Legal Name: First ____________________________ MI ____________ Last __________________________________

Nick Name: _____________________  Age: _______     Birthdate: ______________       S.S.#: ____________________

Address: __________________________________________________________________________________________

Cell Phone (____)________________  Home Phone (____)________________  Work Phone (____)_________________

Employer Name: ____________________________________________Occupation:_____________________________

Spouse’s Name: ____________________________________________ Age: ______ Birthdate: ______________

Spouse’s Employer: ________________________________________________ Occupation: ______________________

Emergency Contact: __________________________ Phone: (____)______________ Relationship: __________

<table>
<thead>
<tr>
<th>Children’s Names</th>
<th>Age</th>
<th>Birthdate</th>
<th>Relationship to you</th>
<th>Lives with you</th>
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</tbody>
</table>

List all other members (other than spouse & children) living in your home (family and/or friends):

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Birthdate</th>
<th>Relationship to you</th>
<th>Occupation</th>
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SECTION 2: PRESENTING INFORMATION

Describe the reason you are seeking counseling: ___________________________________________________________

___ # years you have lived in this area      ___ # of years in present relationship      ___ # of prior marriages

Present relationship/marriage is: _____ very happy  _____ pleasant  _____ tolerable  _____ poor

Have you had suicidal thoughts in the past? ___ Never      ___ Sometimes       ___ Often

Do you currently have suicidal thoughts? ___ Never      ___ Sometimes       ___ Often

Have you ever attempted suicide? ___ yes   ___ no  

if yes, please explain ______________________________________

__________________________________________________________________________________________________

Rate the following on how often it is difficult to function at your normal level: Never = 0   Sometimes = 1  Often = 2

___ Anxiety  ___ Manic states  ___ Anger  ___ Depression  ___ Concentration

Rate the problems that apply to you: No Problem = 0      Mild = 1      Moderate = 2      Severe = 3

___ Nervousness  ___ Depression  ___ Fears  ___ Shyness  ___ Sexual problems

___ Drug use  ___ Separation  ___ Divorce  ___ Memory  ___ Alcohol use

___ Friends  ___ Anger  ___ Self control  ___ Health problems  ___ Stomach problems

___ Relaxation  ___ Headaches  ___ Tiredness  ___ Work  ___ Legal matters

___ Stress  ___ Sleep  ___ Energy  ___ Insomnia  ___ Making decisions

___ Loneliness  ___ Inferiority  ___ Pain  ___ Education  ___ Concentration

___ Nightmares  ___ Temper  ___ Appetite  ___ Unhappiness
SECTION 3: CLIENT HEALTH INFORMATION

Height _________  Weight_________    Physical condition: ____ Excellent     ____ Good      ____ Fair      ____ Poor

Name of Primary Care Physician __________________________________________________________

Most Recent doctor Visit (when & why) ___________________________________________________________________

List any health problems for which you are currently receiving treatment: ____________________________________________
__________________________________________________________________________________________________

Do you have a physical fitness program? ____ Not at all          ____ Occasionally         ____ Regularly

Do you have any Allergies? ____yes   ____ no  if yes, please explain ______________________________________

Any major surgical operations? ____yes   ____ no  If yes, for what & when? ____________________________________

Current Medications:

<table>
<thead>
<tr>
<th>Name</th>
<th>Start Date</th>
<th>Dosage/Frequency</th>
<th>Taken For</th>
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Sleeping Habits:  __ No problems     _____  Difficulty falling asleep    _____  Early morning waking

____ Nightmares/dreams    _____  Insomnia     _____  Restless _____  Sleep too much

Eating Habits: Eating problems? ____ yes   ____ no     # meals you normally eat daily? ____    # snacks daily? __

If yes, please explain __________________________________________________________

Do you have, or have you had in the past, any eating disorders?  ____ yes   ____ no

Sexual History: Please describe any sexual problems that you have experienced in the past or are currently experiencing:
__________________________________________________________________________________________

Drug/Alcohol History:  Do you ever drink alcohol ____ yes   ____ no If yes, how often?________________________

Do you drink alcohol to alter behavior/mood? _____ yes   _____ no If yes, how often?________________________

Do you use drugs to alter behavior/mood    _____ yes     _____ no  If yes, how often?________________________

Have you ever received treatment for alcohol/drug use?   _____ yes   _____ no  If yes, when?________________________

Have you ever been charged with a DWI/DUI?   _____ yes  _____ no  If yes, when?__________________________

Do you now or have you ever attended AA/NA/ALANON? ____ yes   ____ no  If yes, when?__________________________

Counseling History  Have you received previous psychiatric/psychological help or counseling? ___Yes ___No

Date(s)             Name of therapist/doctor           Name of Practice & location
_____________________________   __________________________  ________________________________________
_____________________________   __________________________  ________________________________________
_____________________________   __________________________  ________________________________________

Have you ever been hospitalized for substance abuse, eating disorder or other psychiatric problems? ___Yes ___No

Date(s)             Reason      Name of Hospital & location
_____________________________   __________________________  ________________________________________
_____________________________   __________________________  ________________________________________
_____________________________   __________________________  ________________________________________

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**SECTION 4: CLIENT EDUCATIONAL AND VOCATION INFORMATION**

**Education** - Indicate your highest level of education:

- _____ Grade school   # of years completed __
- _____ High school   # of years completed __
- _____ College   # of years completed __   area of study ________________________________
- _____ Advanced degree # of years completed __   area of study ________________________________

Describe any specialized skills for which you have training: certification or licensure: _____________________________

__________________________________________________________________________________________________

School has been   ____ easy      ____ fairly easy      ____ difficult       ____ very difficult

Any specific area of difficulty? ________________________________________________________________________

Areas of Achievement: _______________________________________________________________________________

**Vocation** - Describe your employment history for the past five years beginning with your current position:

<table>
<thead>
<tr>
<th>Employer</th>
<th>Position</th>
<th>Time on job</th>
<th>Reason for leaving</th>
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<tr>
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Has your employer/supervisor ever expressed any of these concerns? (Check all that apply)

- ____ Missing too much work
- ____ Assigned too much
- ____ Irresponsibility
- ____ Poor/bad attitude
- ____ late too often
- ____ Increased errors
- ____ Difficulty getting along with other workers/supervisors
- Other ______________________________________

**Military History**

Have you ever served in the military service? ____ yes      ____ no   If yes, branch of service: ____________

Age at enlistment: _______  Rank at discharge: _____________________________   Any combat? ____ yes      ____ no

If yes, please describe: __________________________________________________________________________

**Financial History**

Do you have a system of saving money? ____ yes      ____ no

Are you currently, or have you ever been, in a financial crisis? ____ yes      ____ no

Explain: _____________________________________________________________________________________

For couples, do you divide your income and bills ______ or do you combine and share income and bills? _____

**Spiritual History**

Do you expect your spiritual life to be included in therapy? ____ yes      ____ no

Were you brought up in any religious tradition? ____ yes      ____ no

What is your current affiliation? ________________________________

Do you attend services? ____ regularly   ____ most of the time   ____ occasionally   ____ never

Page 3 of 4
SECTION 5: CLIENT BACKGROUND INFORMATION

Family History

Mother: Name ___________________________________ Age _______ (if deceased, when?) _____________________

   Nationality ____________________________Highest level of education ______________________________
   Occupation ______________________________Abilities/special interests _______________________________
   General Health Status: Physical ____________________________ Emotional: ______________________________

   Describe your relationship with her: ________________________________________________________________

Father: Name _________________________________ Age _________ (if deceased, when?) ______________________

   Nationality ______________________________Highest level of education ______________________________
   Occupation ______________________________Abilities /special interests _______________________________
   General Health Status: Physical ____________________________ Emotional: ______________________________

   Describe your relationship with him: ________________________________________________________________

Brothers & Sisters Names & Ages:

_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Where did you grow up? ____________________________________________________________

With whom did you live during your childhood? (Check all that apply)

   ___ Mother & Father       ___ Mother only       ___ Father only       ___ Mother & Stepfather
   ___ Father & Stepmother     ___ Relatives      ___ Foster Parents    Other: ______________________________________

Describe you childhood: ___ Very happy      ___ Pleasant     ___ Bearable     ___ Unhappy      ___ Mixed

   Please explain ______________________________________________________________________________________

Describe you adolescence: ___ Very happy      ___ Pleasant     ___ Bearable     ___ Unhappy      ___ Mixed

   Please explain: _____________________________________________________________________________________

Check all that apply:   ___ I was not abused as a child       ___ I witnessed abuse in the home

   ___ I was emotionally abused   ___ I was physically abused       ___ I was sexually abused as a child

   Please explain: ________________________________________________________________

Any family history of alcohol and/or drug abuse? ___ yes      ___ no      If yes, who, explain? __________________________

Have any of your family members ever received counseling? ___ yes      ___ no      if yes, who and for what reason?

Any Addition Comments: ______________________________________________________________________________
Insurance Information

Client’s Name: ________________________________________________________________________________

Employee Assistance Program (EAP) Company (if applicable): __________________________________________

Employee Name: ______________________________________  SS#: _____________________ DOB: __________

Employer: ___________________________________________ Patient Relationship to Employee: ______________

EAP Phone #: ________________________________________ Authorization #: _____________________________

Primary Insurance Company Name:_______________________________________________________________

Full Name of Insured (employee):___________________________________________________________________

Policy Number (ID #): ___________________________ Group Number: ______________________________________

Insured Date of Birth: ___________________________ Insured’s Social Security #: _________________________

Insured’s Employer: _____________________________________________________________________________

Patient Relationship to Insured: __________________________________________________________________

Insured’s Address (if different than client): ___________________________________________________________

Secondary Insurance: We normally do no submit claims to Secondary Insurance Companies. If you have a secondary insurance then you will be responsible for your primary insurance co-insurance/co-pay unless you have made other arrangements with us. We can give you a statement showing that you paid and then you can submit that along with the primary insurance EOB (explanation of benefits) to your secondary insurance for reimbursement. There are some primary insurance companies like Medicare that will automatically forward claims to the secondary.

Secondary Insurance Company Name:_______________________________________________________________

Full Name of Insured (employee):___________________________________________________________________

Policy Number (ID #): ___________________________ Group Number: ______________________________________

Insured Date of Birth: ___________________________ Insured’s Social Security #: _________________________

Insured’s Employer: _____________________________________________________________________________

Patient Relationship to Insured: __________________________________________________________________

Insured’s Address (if different than client): ___________________________________________________________

ASSIGNMENT OF BENEFITS AUTHORIZATION:

I hereby assign to Associated Counselors of Tidewater any insurance or other third-party benefits available for psychiatric/counseling care provided to me. I understand that Associated Counselors of Tidewater Practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Associated Counselors of Tidewater, I agree to forward to Associated Counselors of Tidewater all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

RECORD RELEASE AUTHORIZATION:

I hereby authorize Associated Counselors of Tidewater to furnish medical information to my insurance carrier(s).

__________________________   ______________________ __ _________
Signature of Patient/Legal Guardian   Printed Name     Date

PLEASE GIVE THE OFFICE STAFF/YOUR THERAPIST YOUR INSURANCE CARD(S) TO COPY.
Associated Counselors of Tidewater, Inc.

POLICIES & PROCEDURES

Associated Counselors of Tidewater, Inc. is committed to providing professional services to the highest quality and standards. In order to serve our clients efficiently and responsibly we require agreements be made as to the following policies.

Fees for services:

As a client of Associated Counselors of Tidewater, Inc., you will be required to pay for each session at the time of the each visit.

- Diagnostic Interview (1st session): $150.00
- Court Appearance (including travel): $200.00/hour, $400.00 advanced deposit
- Individual/Family Therapy (45 minutes): $125.00
- Drug Test: $30.00
- Individual/Family Therapy (60 minutes): $165.00
- Typed Letter or Report: $25.00
- Group Therapy: $55.00
- Release of Records: $25.00

Missed appointments/Late Cancellation: $60.00*

We accept checks, cash, & credit/debit cards. There is a $1.00 convenience fee if you use a credit/debit card.

CLIENTS WITH INSURANCE

Your copay and deductible are quoted by your insurance company but does not guarantee claim payment. We suggest that you also call to verify your benefits for out-patient mental health and verify whether or not pre-authorization is required. As a client of Associated Counselors of Tidewater, Inc., you will be required to pay your co-pay at each visit. You will also be required to pay any deductible amount at each visit until the deductible is met. You will be responsible for any denied payments from your insurance company.

CLIENTS WITHOUT INSURANCE

You will be required to pay for each session at the time of the each visit. Self-pay rates are as follows:

- Diagnostic Interview (1st session): $90.00
- Individual, Couple, or Family Therapy (45 minutes): $70.00
- Individual, Couple, or Family Therapy (60 minutes): $90.00
- Group therapy: $35.00

COLLECTIONS FEES:

Once you stop receiving services here, if you have a balance we will send you one statement. If you do not make a payment then your account will be turned over to a collections agency and a fee of 35% of your balance will be added.

TERMINATION POLICY

You are under no obligation to continue services should you decide to terminate at any time. However, we strongly urge that the counselor be notified in person regarding this decision so that it can be discussed openly to help your situation.

CANCELLATION POLICY

Cancellations must be made by 4:00 PM the day before your scheduled appointment. This allows us time to try to fill the slot with someone else. You will be responsible for the payment of the $60.00 fee for any missed appointments or late cancellations.

Insurance companies will not cover missed or canceled appointments.

If we are not available to answer the phone you can leave a message any time and any day letting us know you need to cancel. More than two (2) late canceled or missed appointments represent a break in the contract and could lead to termination of services.

I understand and have received a copy of these POLICIES & PROCEDURES and the Notice of Privacy Practices.

I give my consent for treatment.

I give my consent for treatment.

Printed Name of Client: _____________________________________________ Date: ____________

Signature of Client: ________________________________________________ Date: ____________

For child or for adults when someone other than the client is responsible for payment list below:

Printed Name of Responsible Party: ________________________________ Relationship to client: ____________

Signature of Responsible Party: ____________________________________ Date: ____________

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Associated Counselors of Tidewater, Inc.

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We accept checks, cash, & credit/debit cards. There is a $1.00 convenience fee if you use a credit/debit card.

CLIENTS WITH INSURANCE
Your copay and deductible are quoted by your insurance company but does not guarantee claim payment. We suggest that you also call to verify your benefits for out-patient mental health and verify whether or not pre-authorization is required. As a client of Associated Counselors of Tidewater, Inc., you will be required to pay your co-pay at each visit. You will also be required to pay any deductible amount at each visit until the deductible is met. You will be responsible for any denied payments from your insurance company.

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Group therapy: $35.00

COLLECTIONS FEES:
ONCE YOU STOP RECEIVING SERVICES HERE, IF YOU HAVE A BALANCE WE WILL SEND YOU ONE STATEMENT. IF YOU DO NOT MAKE A PAYMENT THEN YOUR ACCOUNT WILL BE TURNED OVER TO A COLLECTIONS AGENCY AND A FEE OF 35% OF YOUR BALANCE WILL BE ADDED.

TERMINATION POLICY
You are under no obligation to continue services should you decide to terminate at any time. However, we strongly urge that the counselor be notified in person regarding this decision so that it can be discussed openly to help your situation.

CANCELLATION POLICY
CANCELLATIONS MUST BE MADE BY 4:00PM THE DAY BEFORE YOUR SCHEDULED APPOINTMENT. THIS ALLOWS US TIME TO TRY TO FILL THE SLOT WITH SOMEONE ELSE. YOU WILL BE RESPONSIBLE FOR THE PAYMENT OF THE $60.00 FEE FOR ANY MISSED APPOINTMENTS OR LATE CANCELLATIONS.
Insurance companies will not cover missed or canceled appointments.
If we are not available to answer the phone you can leave a message any time and any day letting us know you need to cancel. More than two (2) late canceled or missed appointments represent a break in the contract and could lead to termination of services.

Client Copy
Associated Counselors of Tidewater, Inc.

NOTICE OF PRIVACY PRACTICES

Effective Date: January 1, 2005

This notice describes the uses and disclosures of psychiatric information that may be made by Associated Counselors of Tidewater. Associated Counselors of Tidewater is required by law to maintain the privacy of your psychiatric information and to provide you with this notice of its legal duties and privacy practices with respect to psychiatric information. We are required to abide by the notice in effect when we were created.

We understand that psychiatric information about you and your health is personal. We are committed to protecting psychiatric information about you. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements.

This notice applies to all of the records of your care generated by our office. This notice will tell you about the ways in which we may use and disclose psychiatric information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of psychiatric information.

WHO WILL FOLLOW THIS NOTICE.

This notice describes our practice’s privacy practices and that of:

• Any counselor authorized to enter information into your psychiatric chart.
• All departments and units of the practice.
• All employees, staff and other office personnel.
• All these individuals, sites and locations follow the terms of this notice. In addition, these individuals, sites and locations may share psychiatric information with each other or with third party specialists for treatment, payment or office operations purposes described in this notice.

OUR PLEDGE REGARDING PSYCHIATRIC INFORMATION:

We understand that psychiatric information about you and your health is personal. We are committed to protecting psychiatric information about you. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements.

This notice applies to all of the records of your care generated by our office.

This notice will tell you about the ways in which we may use and disclose psychiatric information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of psychiatric information.

We are required by law to:

• Make sure that psychiatric information that identifies you is kept private;
• Give you this notice of our legal duties and privacy practices with respect to psychiatric information about you; and follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose psychiatric information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

• For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to people outside our office who may be involved in your care after you leave the office, such as family members or others we use to provide services that are part of your care provided you have consented to such disclosure. These entities include third party physicians, hospitals, nursing homes, pharmacies or clinical labs with whom the office consults or makes referrals.
• For Payment. We may use and disclose psychiatric information about you so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your psychiatric plan information about treatment you received at the office so your behavioral health plan will pay us or reimburse you for the services. We may also tell your behavioral health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
• Appointment Reminders. We may use and disclose information to contact you as a reminder that you have an appointment for treatment at the office.
• Treatment Alternatives. We may use and disclose psychiatric information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
• Individuals Involved in Your Care or Payment for Your Care. We may release psychiatric information about you to a friend or family member who is involved in your care provided you have consented to such disclosure. We may also give information to someone who helps pay for your care. In addition, we may disclose psychiatric information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
• As Required By Law. We will disclose psychiatric information about you when required to do so by federal, state or local law.
• To Avert a Serious Threat to Health or Safety. We may use and disclose psychiatric information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Health Oversight Activities. We may disclose psychiatric information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose psychiatric information about you in response to a court or administrative order. We may also disclose psychiatric information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

If you have any questions about this notice, please contact Associated Counselors of Tidewater.
Law Enforcement. We may release psychiatric information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the office; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding psychiatric information we maintain about you:

• Right to Inspect and Copy. You have the right to inspect and/or receive a copy of your psychiatric information that may be used to make decisions about your care. To inspect and/or receive a copy of psychiatric information that may be used to make decisions about you, you must submit your request in writing to Associated Counselors of Tidewater, Inc. If you request a copy of the information, we may charge a fee for the costs of copying and mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances.

• Right to Amend. If you feel that psychiatric information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, your request must be made in writing and submitted to your counselor. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the psychiatric information kept by or for our office;
- Is not part of the information which you would be permitted to inspect and copy; or is in accurate and complete.

• Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list of accounting of disclosures, you must submit your request in writing to the Associated Counselors of Tidewater, Inc. Office Manager.

Records Department. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you a fee for the costs of copying and mailing or other supplies associated with your request. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

• Right to Request Restrictions. You have the right to request a restriction or limitation on the psychiatric information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the psychiatric information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to Associated Counselors of Tidewater, Inc. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

• Right to Request Confidential Communications. You have the right to request that we communicate with you about psychiatric matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Associated Counselors of Tidewater, Inc., Office Manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

• Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

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 psychiatric information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the top left-hand corner, the effective date. In addition, each time you register we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a written complaint with Associated Counselors of Tidewater, Inc. 287 Independence Blvd., Pembroke 2, Ste. 219, Virginia Beach, VA 23462, Phone (757) 757-490-6960. Or you can file your complaint with the office of Civil Rights within the Department of Health and Human Services by visiting their Web site at www.hhs.gov/ocr/hipaa. All complaints must be submitted in writing.

You will not be penalized or retaliated against for filing a complaint.

OTHER USES OF PSYCHIATRIC INFORMATION

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