Child 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 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!

Associated Counselors of Tidewater, Inc.

Child Client Information

SECTION 1: CLIENT (CHILD'S) INFORMATION

Today's Date: _____

Client's Legal Name: First _____ MI_____ Last _____

Nickname: _____ Age: _____ Birthdate: _____ S.S.#: _____

Child's cell Phone: (____)_____ (optional for teenagers- especially if they may come by themselves)

SECTION 2: CLIENT PRESENTING ISSUES

Describe the reason you are seeking help for your child: _____

_____

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

___Fears	___Headaches	___Appetite	___Legal matters	___Parent Divorce	___Suicidal thoughts
___Sleep	___Drug use	___Alcohol use	___Concentration	___Parent Separation	___Suicidal Actions
___Friends	___Anger	___Tiredness	___Self control	___Health problems	___Academic problems
___Work	___Moods	___Insomnia	___Sexual problems	___Sexual Abuse	___Refusal to go to school
___Stress	___Anxiety	___Stealing	___Relaxation	___ Physical Abuse	___ Arguments with parents
___Pain	___Memory	___Loneliness	___Nightmares	___Health problems	___Neglect by parents
___Temper	___Shyness	___Nervousness	___Stomach problems	___ Making decisions	___Home behavior problems
___Lying	___Inferiority	___Energy	___Depression	___Family Change	___School behavior problems

___Bed-wetting ___ Unhappiness Other: _____

How would you describe the child? Check all that apply:

___ Active	___ Passive	___ Happy	___ Unhappy	___ Content	___ Calm	___ Nervous
___ Fearful	___ Moody	___ Outgoing	___ Noisy	___ Lonely	___ Quiet	___ Coordinated
___ Clumsy	___ Dull	___ Intelligent	___ Athletic	___ Worries	___ Shy	___ Stubborn
___ Sensitive	___ Creative	___ Aggressive	___ Impulsive	___Immature	___ Hyper	Other: _____

SECTION 3: CLIENT MEDICAL INFORMATION

Name of your child's Primary Care Physician: _____ Phone: _____

Any health problems for which your child is currently receiving treatment: _____

_____

Current Medications:

Name	Start Date	Dosage/Frequency	Taken For:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child received previous psychiatric/psychological help or counseling? ____ Yes ____ No

If Yes list Date(s), Name of Clinician & Name of Practice:_____

_____

Has your child ever been hospitalized for substance abuse, alcoholism, eating disorder or other psychiatric problems?

____ Yes ____ No If Yes, Date(s), Name of Hospital: _____

SECTION 4: PARENT(S) / GUARDIAN(S) FILLING THIS OUT (Must have legal custody)

Address: Street _____

City _____ **State:** _____ **Zip:** _____

Do biological parents live together? ____ yes ____ no If no, list other parent on next page in Section 5

Relationship Start Date: _____ **Marriage Date:** _____ **Separation Date:** _____ **Divorce Date:** _____

Your marriage/relationship is/was: ___ Very poor ___ tolerate each other ___ relatively happy ___ very happy

If #2 Parents/Guardians below is a step-parent, are you married? ____ yes ____ no # Years together: ____

Your marriage/relationship is: ___ Very poor situation ___ tolerate each other ___ relatively happy ___ very happy

#1 Parent/Guardian filling this out & lives at above address (must have legal custody).

Relationship to child: _____ Name: First_____ MI _____ Last_____

Nickname: _____ Birthdate:_____ S.S.#:_____

Cell Phone: (_____)_____ Home Phone: (_____)_____ Work Phone: (_____)_____

Employer Name:_____

Occupation:_____ What days & hours do you work: _____

Physical custody: ___ N/A ___ Primary ___Shared ___ Visitation ___ Supervised visitation

Legal custody: Has access to medical records & allowed to make medical decisions ____ yes ____ no

#2 Second Parent/Step-parent/Guardian - lives at above address.

Relationship to child: _____ Name: First_____ MI _____ Last_____

Nickname: _____ Birthdate:_____ S.S.#:_____

Cell Phone: (_____)_____ Home Phone: (_____)_____ Work Phone: (_____)_____

Employer Name:_____

Occupation:_____ What days & hours do you work: _____

Physical custody: ___ N/A ___ Primary ___Shared ___ Visitation ___ Supervised visitation ___ No contact allowed

Legal custody: Has access to medical records & allowed to make medical decisions ____ yes ____ no

If this person does not have custody do you give them permission to communicate with our staff? ____ yes ____ no

If yes: ____ schedule/cancel appts ____ speak to therapist about treatment ____ account info (insurance/payments)

List all members (other than client and parents) living in this home (family and/or friends):

Name	**Age**	**Birth date**	**Relationship**	**Occupation**

Do you have any religious affiliation? _____

Do you attend Church? (Check One) ____ Regularly ____ Most of the time ____ Occasionally ____ Never

SECTION 5: OTHER PARENT(S) / GUARDIAN(S) Fill in as much info that is known

Address: Street _____

City _____ **State:** _____ **Zip:** _____

#1 Parent/Guardian lives at above address

Relationship to child: _____ Name: First_____ MI _____ Last_____

Nickname: _____ Birthdate:_____ S.S.#:_____

Cell Phone: (_____)_____ Home Phone: (_____)_____ Work Phone: (_____)_____

Employer Name:_____

Occupation:_____ What days & hours do you work: _____

Physical custody: ___ N/A ___ Primary ___Shared ___ Visitation ___ Supervised visitation ___ No contact allowed

Legal custody: Has access to medical records & allowed to make medical decisions ____ yes ____ no

If this person does not have custody do you give them permission to communicate with our staff? ____ yes ____ no

If yes: ____ schedule/cancel appts ____ speak to therapist about treatment ____ account info (insurance/payments)

#2 Second Parent/Step-parent/Guardian lives at above address.

Relationship to child: _____ Name: First_____ MI _____ Last_____

Nickname: _____ Birthdate:_____ S.S.#:_____

Cell Phone: (_____)_____ Home Phone: (_____)_____ Work Phone: (_____)_____

Employer Name:_____

Occupation:_____ What days & hours do you work: _____

Physical custody: ___ N/A ___ Primary ___Shared ___ Visitation ___ Supervised visitation ___ No contact allowed

Legal custody: Has access to medical records & allowed to make medical decisions ____ yes ____ no

If this person does not have custody do you give them permission to communicate with our staff? ____ yes ____ no

If yes: ____ schedule/cancel appts ____ speak to therapist about treatment ____ account info (insurance/payments)

The 2 Parents/Guardians above are married? ____ yes ____ no # Years in Marriage/Relationship: ____

Their marriage/relationship is: ___ Very poor situation ___ tolerate each other ___ relatively happy ___ very happy

Additional Comments: _____

List all members (other than client and parents) living in this home (family and/or friends):

Name	Age	Birth date	Relationship	Occupation

Any religious affiliation? _____

Attend Church? (Check One) ____ Regularly ____ Most of the time ____ Occasionally ____ Never

SECTION 6: CLIENT INFORMATION

Please answer the following sections to the best of your knowledge. Try to avoid simple yes or no answers and try to give details since the more we know about your child, the better job we can do. Thank you for your time.

Bedtime_____ Time of arising_____ Number of hours of sleep_____

Sleep Patterns (restless, nightmares, normal, very sound) _____

Does he/she resist sleep? _____

General appetite and eating habits _____

Any security items? _____

Childcare arrangements (baby-sitter, relatives) _____

_____

Child's activities, hobbies: _____

Friendships/peer relationships: _____

Description of home environment (apartment, house, ample place space, neighbors close by)_____

_____

Child's bedroom (does/she share a room, help pick-up, show an interest in decorating)? _____

_____

SECTION 7: FAMILY RELATIONSHIPS

Any significant health or emotional problems with other children? _____

_____

Sibling rivalry or jealousy _____

Does this child particularly like or relate well to any other brother or sister? _____

_____

How would you describe father-child relationship? _____

_____

How would you describe mother-child relationship? _____

_____

Activities with the whole family? _____

_____

With one parent? _____

Child's responsibilities _____

Does he/she receive an allowance? _____

How is it used? _____

Discipline Type? _____

Person who administers discipline: _____

Are you consistent in your discipline? _____

How does your child react to discipline? _____

SECTION 8: EDUCATIONAL INFORMATION

School:_____ Present Grade:_____

Teacher(s):_____

Is this a school referral? YES NO If yes, what is the school's reason for the referral? _____

_____

How do you feel about your child's academic progress? _____

What are your expectations for him/her? _____

What do you think is your child's attitude toward school? _____

Any unpleasant school experiences? _____

_____

Grades repeated? _____

Does the child resist going to school? _____

What is his/her most difficult subject? _____

What is his/her best subject? _____

Where does he/she study? _____Do parents help? _____

Have you had a conference with his/her teacher this year? _____

Other comments on school: _____

Other testing done (private or school): _____

Prior Schools Attended	Grade Level(s)	Performance
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 9: BIRTH HISTORY

Length of Labor? _____ ___ full term ___ premature Was anesthesia use for delivery? ___ Yes ___ No

Did you have complication during pregnancy-bleeding, special medication, toxemia, diabetes, RH factor:

_____

_____

Was labor induced? ___ Yes ___ No Was he/she put in an incubator? ___ Yes ___ No

Did the child have any problems immediately after birth: blueness difficulty in breathing, eating, etc.? ___ Yes ___ No

_____

Child's birth weight: _____ Did the child feed normally? ___ Yes ___ No

When the child was held was he/she rigid or relaxed? _____

Any physical defects? _____

Did he/she show irritability, difficulty in sleeping, cry a lot: _____

SECTION 10: CHILDHOOD DEVELOPMENT

Was the child early, average or late in doing the following: early = 1 average = 2 late = 3

____Hold up head ____Sit alone ____Crawl ____Talk ____Bowel control

____Dress alone ____Feed self ____Walk ____Bladder control

Does he/she now have any difficulty using scissors, paste, writing, etc.?_____

_____

Comparison of development to that of brothers or sisters: _____

_____

Describe child as a toddler: _____

_____

Is child right or left handed? _____

Any high fevers? _____

Any convulsions or staring spells? _____

Hospitalizations, operations? _____

Any history of ear infections, hearing impairments? _____

Any injuries or accidents, particularly blows to the head (car/bike falls) _____

SECTION 11: PARENTAL INFORMATION

Biological Mother: Name: _____

Birthplace: _____ Education Attainment:_____

Difficulty in school? ____ yes ____ no _____

Other Marriages:_____

Any current or past physical or mental problems?_____

_____

Did any family members have learning difficulties or mental problems?_____

_____

Biological Father: Name: _____

Birthplace: _____ Education Attainment:_____

Difficulty in school? ____ yes ____ no _____

Other Marriages:_____

Any current or past physical or mental problems?_____

_____

Did any family members have learning difficulties or mental problems?_____

_____

Any Additional Comments: _____

_____

Name of person who filled this out: _____ **Signature:** _____ **Date:** _____

Associated Counselors of Tidewater, Inc.

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
Individual/Family Therapy (45 minutes): $125.00
Individual/Family Therapy (60 minutes): $165.00
Group Therapy: $55.00
Court Appearance (including travel): $200.00/hour, $400.00 advanced deposit
Drug Test: $30.00
Typed Letter or Report: $25.00
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 very 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 **4:00PM 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 APPOINMENTS 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.

Printed Name of Client: _____

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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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 HOW PSYCHIATRIC INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions about this notice, please contact Associated Counselors of Tidewater.

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 the practice's office personnel who are involved in taking care of you at the office or elsewhere. We also 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.

Client Copy

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.

To have a paper copy of this notice mailed to you, you must make your request in writing to the **Associated Counselors of Tidewater, Inc. Office Manager.**

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

Other uses and disclosures of psychiatric information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose psychiatric information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose psychiatric information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Client Copy