revive
Clinical Counseling

AGREEMENT FOR SERVICES/INFORMED CONSENT

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

I, your therapist, Whitney Schlife, am a Licensed Professional Clinical Counselor (LPCC 2263). I may discuss my professional background with you and provide you with information regarding my experience, education, and professional orientation and you are free to ask questions at any time. I will never operate outside of the scope of my professional training and as such I will not provide any legal, financial, or other advisement outside of the services typical to a therapeutic setting.

The Therapy Process
The experience of therapy differs for everyone since each therapist and each individual entering therapy is unique. In general, psychotherapy includes therapists helping clients get to know themselves better and increase their self-awareness. Therapy is not a process of therapists telling clients how to live or what choices to make. The purpose of the therapeutic relationship is to help the client change their life in a positive way.

In the beginning, the client and therapist work together to determine the exact goal(s) that the client wants to achieve through therapy. Treatment goals can be general or specific depending on the problem that brought the client to therapy. In general, therapists are trained to identify patterns of behavior and thought that clients may or may not be aware of. Often old patterns can stand in your way, making change difficult or impossible. Therapists can help you break out of time-worn ruts and find new ways of living. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Client's Rights and Confidentiality
You have the right to a confidential therapeutic relationship. Within certain legal limits (see #3 below), information revealed by you during the course of therapy will be kept completely confidential and will not be revealed to any person without your written permission.

I. You have the right to know the content of your records at any time and I have the right to provide you with the complete records or a summary of their content.
2. If you ask me, I can release any part of your records on file to any person you specify. I will tell you when you make your request whether releasing that information to that agency or person might be harmful to you at any time. Requests for records must be made in writing.
3. Under certain legally defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:
    a. If you reveal information about active child abuse or neglect, elder abuse, or dependent adult psychical abuse I must make a report to protective services. When a perpetrator of child abuse is in contact with minors and there is reasonable suspicion that he/she may still be abusing minors, I must also report that information.
    b. If you seriously threaten harm or death to another person, I am required to warn the intended victim and notify the appropriate law enforcement agencies.
    c. If you are in therapy or being tested due to an order of a court or lawyer, the result to the treatment or tests ordered must be revealed to that court or lawyer. I do not provide court ordered testing but can provide referrals if needed.
    d. If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in that subpoena. I will not voluntarily participate in any litigation or custody dispute. Should I be subpoenaed, you will agree to reimburse for time spent in preparation, travel, or other time in which I make myself available for such an appearance at the customary hourly rate of $125.
    e. If you are in a lawsuit where emotional harm is being claimed, the opposing side may subpoena your therapy records.
4. Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I not reveal any personally identifying information regarding you or your family members or caregivers.

5. You have the right to ask questions about any of the procedures used in the course of therapy. I will explain my customary approach and methods to you.
6. Communications between therapists and patients who are minors are confidential. Unless serious safety concerns are revealed by the minor, what is shared within the therapeutic process will remain confidential. However, I will not hold secrets which could prove to be harmful to the patient or others. When concerns need to be addressed with the parent(s) I will work with the minor to disclose said information. Similarly, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, I, in the exercise of my professional judgment, may discuss the treatment progress of a minor client with the parent or caregiver.
7. Communication in the context of couples therapy must be open in order to be productive. Within couples therapy, there may be times in which I meet with individual members of the couple. This time will be used to process emotions and prepare to address issues within the couple at a following session. I will not hold secrets. That which is discussed in individual sessions will be addressed in a future session.
8. You have the right to choose NOT to receive therapy from me. If you choose this, I will provide you with names of other qualified professionals whose services you might prefer.
9. You have the right to terminate therapy at any time without any financial, legal, or moral obligations other than those you've already incurred.
10. I have the right to terminate therapy with you under the following conditions:
    - **a.** When I believe that therapy is no longer beneficial to you.
    - **b.** When I believe that you will be better served by another professional, whom I will recommend. If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If I have written consent from you, I will provide that professional with the essential information he or she requires.
    - **c.** When you have not paid for the last two sessions, unless special arrangements have been made.
    - **d.** When you have failed to show up for your last two therapy sessions without a 24-hour notice.

If any of these situations apply, I will send you a certified letter to your address of record to inform you of the decision, and I will give you the names of several therapists for your future counseling needs.

Records and Record Keeping
Therapist may take notes during session, and will also produce other notes and records regarding Client's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapists are required to maintain. Should Client or Representative request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Client, or Representative, with a treatment summary in lieu of actual records. Representative will generally have the right to access records regarding Client. However, this right is subject to certain exceptions set forth in California law. Should Representative request access to Therapist's records, such a request will be responded to in accordance with California law.

Clinical Records
I am required to keep appropriate records of the psychological services that I provide. Although psychotherapy often includes discussions of sensitive and private information, normally very brief records are kept noting that you have been here, what was done in session, and a general mention of the topics discussed. You have the right to a copy or summary of your file at any time. You have the right to request that a copy of your file be made available to any other health care provider at your written request. Your records are maintained in a secure location according to HIPAA Standards.

Psychotherapist-Client Privilege and Court Proceedings
The information disclosed by Client, as well as any records created, is subject to the psychotherapist-client privilege. The psychotherapist-client privilege results from the special relationship between Therapist and Client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the Client is the holder of the psychotherapist-client privilege. If Therapist receives a subpoena for records, disposition testimony, or testimony in the court of law, Therapist will assert the psychotherapist-client privilege on Client's behalf until instructed, in writing, to do otherwise by a person with the authority to waive the privilege on Client's behalf. When a Client is a minor child, the holder of psychotherapist-client privilege is either the minor, a court-appointed guardian, or minor's counsel. Parents typically do not have the authority to waive the psychotherapist-client privilege for their minor child, unless given such authority by a court of law. Representative is encouraged to discuss any concerns regarding the psychotherapist-client privilege with his/her attorney.

Fees and Insurance
- The fee per individual session is $90 and $110 per couple/family session, unless other arrangements have been made prior to the start of therapy. Sessions are typically 50 minutes long.

• The fee for missed sessions or sessions canceled without 24-hr notice is $60.

Fees are payable at the time that services are rendered. You may leave therapy at any time and are only contracting to pay for the completed therapy sessions or sessions missed without providing a 24-hour notice. Your appointment is reserved for you and cannot be filled on short notice, therefore 24-hr notice is required for cancellation. Every client must keep an updated Credit Card Authorization on file. The Credit Card Authorization will be utilized for cancellations with less than a 24-hour notice, appointments missed without notice (no-show), and insurance refusal to pay.

Please inform Therapist if you wish to utilize health insurances to pay for services. If I am a contracted provider for your insurance company, your copayment will be provided by you at the time of service. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. If your insurance company declines any of your claims or does not pay within 60 days of billing, you will be responsible for the full amount of the bill. This is typically due to a simple delay in processing by the insurance company, but is ultimately your responsibility to handle any delays or denial of payments by your insurance company. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you. Clients who have a PPO Insurance Policy may request from me a Superbill which may be self-submitted by you for reimbursement directly to your insurance company. You also agree that you will pay the standard fees at the time of service, regardless of what reimbursement you may receive from your insurance at a later date. If for some reason, you find that you are unable to continue paying for your therapy, you should inform me. I will help you consider any options that may be available to you at that time, including a fee that is reasonable for both of us.

Dual Relationships
Therapy never involves sexual, business, or any other dual relationships that could impair my objectivity, clinical judgment, or therapeutic effectiveness or could be exploitative in nature. Please discuss with me if you have questions or concerns.

Office Policies

Payment of Services: You are expected to pay for services at the time they are rendered unless other arrangements have been made. I am able to accept payment in the form of cash, check, or credit card. There is a $25 fee for checks returned for unsupported funds. Please notify me if issues arise regarding your ability to make timely payment.

Scheduling: You are able to schedule appointments either by phone (951) 404-5636 or by email at whitney@reviveclinicalcounseling.com

Cancellations: Since an appointment reserves time especially for you, a minimum of 24-hour notice is required for rescheduling or cancellation of an appointment. The fee of $60 will be charged for sessions missed without such notification and a Credit Card Authorization must be kept on file in order to process this fee should this occur. You may reschedule or cancel appointments by calling (951) 404-5636 or by email at whitney@reviveclinicalcounseling.com. After 2 missed or late-cancelled appointments, I will restrict scheduling until 48 hours before requested date of service. Additionally, if missed or late-canceled appointments persist, I will terminate treatment.

Office Hours: My business hours are subject to change at any time. Generally, I have sessions available Monday-Friday 9 am to 6pm, by appointment only. I will return phone calls within 1-3 business days.

Therapist Availability/Emergencies: Telephone communication between sessions is welcome; however, I will keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions. Any discussions lasting longer than 15 minutes will require a session fee of $25 per 15 minutes beyond the initial 15 minutes. You may leave a message for me at any time on my confidential voicemail. If you wish me to return your call, please be sure to leave your name and phone number, along with a brief message and whether or not it is ok to leave a voicemail message should I be unable to reach you. If you have an urgent need to speak with me, please indicate in the voicemail message. In the event of an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance or go to the nearest emergency room. In case of a mental health crisis, you call the Riverside Crisis/Suicide Prevention Line at (951) 686-HELP (951-686-4357). Once you are in a stable place, please inform me, via a phone message, if you have called 911 or the crisis line due to a psychiatric emergency.

Email/Text Communication: You can have the confidence that your insights, vulnerable experiences, and feelings will not be repeated outside the therapeutic relationship established. By nature, email and text correspondence is NOT confidential. Though security measures can be effective, it is never 100% protected. My policy regarding email/text usage is as follows: Email/Text correspondence is NOT a substitute for person-to-person therapeutic treatment, unless discussed with me in advance and in person. Email/Text correspondence may be used only for scheduling purposes. Email/Text correspondence will not play a part in your therapy. I will not respond to your emails in general. Anything stated in an email from you will be discussed in session, and in session only. Email/Text correspondence is NOT to be used in the case of an emergency to contact me. If you need to contact me with something that demands immediate attention, please do so by voicemail at the following number: (951) 404-5636, call 911, or go to the emergency room. If it becomes necessary, I will terminate treatment if email/text usage is or becomes inappropriate.

Internet and Social Media: Just as the information that you bring into the therapeutic relationship remains confidential, your life outside of session remains confidential unless you discuss it in session. I do not connect with clients over social media in order to protect the therapeutic relationship from any dual relationships as well as to protect your confidentiality. As a policy, I deny any requests for connection on social media.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefitting from treatment, either of us may elect to initiate a discussion of your treatment alternatives.

PLEASE SIGN THE CONSENT BELOW THAT APPLIES TO YOU. IF ANY MINOR IS INVOLVED IN THERAPY, THE CONSENT TO TREAT A MINOR MUST BE SIGNED.

Adult Consent for Treatment

I, _____, authorize and request Whitney Schlife, LPCC to carry out psychological examinations, diagnostic procedures, and/or treatments that are advisable now or during the course of my care as a patient. I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read and fully understand this Consent for Treatment Form.

_____ _____

Client Date

_____ _____

Therapist's Signature Date

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Consent to Treat a Minor

I require the consent of a parent prior to providing any services to a minor child. If any question exists regarding the authority of a parent of caregiver to give consent for psychotherapy, I will require copies of supporting legal documentation, such as a custody order, prior to the commencement of services. When working with a minor, I respect his/her right to confidentiality. Communications between therapists and patients who are minors are confidential. Unless serious safety concerns are revealed by the minor, what is shared within the therapeutic process will remain confidential. However, I will not hold secrets which could prove to be harmful to the patient or others. When concerns need to be addressed with the parent(s) I will work with the minor to disclose said information. Similarly, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, I, in the exercise of my professional judgment, may discuss the treatment progress of a minor client with the parent or caregiver.

I, _____, as parent/guardian of minor child named _____ authorize and request Whitney Schlife, LPCC to carry out psychological examinations, diagnostic procedures, and/or treatments that are advisable now or during the course of his/her care as a client. I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read and fully understand this Consent for Treatment Form.

_____ _____
Client or Parent/Guardian Signature Date

_____ _____
Therapist's Signature Date

Consent for Couples or Family Therapy

As a couple/family we agree to engage in therapy, which will include both joint and individual sessions. I understand my right to confidentiality in individual sessions, but am willing to waive that right so that information shared in individual session can be shared in joint session at the discretion of the therapist. I also understand that my therapist believes that couple/family therapy is most successful when a family is willing to be completely honest with the therapist and with each other. For this reason, my therapist has explained that she is unwilling to collude with secrets. Where a family member shares information with the therapist it will be discussed in joint sessions to maintain an atmosphere of openness and honesty.

I authorize and request Whitney Schlife, LPCC, to carry out psychological examinations, diagnostic procedures, and/or treatment s that advisable now or during the course of my care as a client. I understand that the purpose of any procedure will be explained to me and subject to my agreement. I have read and fully understand this Consent for Treatment Form.

_____ _____
Client or Parent/Guardian Signature Date

_____ _____
Client or Parent/Guardian Signature Date

_____ _____
Therapist's Signature Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
In December 2000, the Federal Government finalized Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164).

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PAPER & ELECTRONIC PERSONAL HEALTH INFORMATION (PHI)
I am legally required to protect the privacy of your PHI (including paper/electronic), which includes information that can be used to identify you that I've created or received about your past, present or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and this notice must explain, how, when and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply or analyze such information within my practice. PHI is "disclosed" when it is released, transferred, has been given to or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy practices at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office. You can also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I MAY USE AND DISCLOSE YOUR PHI

I will use and disclose your PHI for many different reasons. For some of these disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures, along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations Do Not Require Your Prior Written Consent.

I can use and disclose your PHI without your consent for the following reasons:

1. For treatment: I can disclose your PHI to physicians, psychiatrists, psychologists and other licensed health care providers who provide you with health care services or are involved with your care. For example, if you're being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate our care.
2. To obtain payment for treatment: I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also

provide your PHI to my business associates, such as billing companies, claims processing companies and others that process my health care claims.

3. For health care operations: I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountants, attorneys, consultants and others to make sure I'm complying with applicable laws.
4. Other disclosures: I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Uses and Disclosures Do Not Require Your Consent: I can use and disclose your PHI without our consent for the following reasons:

1. When disclosure is required by federal, state or local law; judicial or administrative proceedings; or law enforcement: For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect, or when ordered in a judicial or administrative proceeding.
2. For public health activities: For example, I may have to report information about you to the county coroner.
3. For health oversight activities: For example, I may have to report information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4. To avoid harm: In order to avoid a serious threat to the health or safety of a person or the public, I may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
5. For specific government functions: I may disclose PHI of military personnel and veterans in certain situations. I may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.
6. For workers' compensation purposes: I may provide PHI in order to comply with workers' compensation laws.
7. Appointment reminders and health related benefits or services: I may use PHI to provide email appointment reminders or give you information about treatment alternatives.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends or others: I may provide your PHI to a family member, friend or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any further uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. ELECTRONIC RECORDS

Electronic records are subject to similar concerns and requirements as paper records. I keep electronic medical records on each patient. The 2005 HIPAA Security Rule provides specific guidance on managing

electronic protected health information. It applies to practitioners who must comply with HIPAA and who store or transmit such information. The rule requires that I take special care in maintaining electronic records and that I conduct a risk analysis of specified issues and security measures appropriate for the practice. The electronic practice management company that I use takes reasonable efforts to maintain their service in a manner that includes appropriate administrative, technical and physical security measures designed to protect the confidentiality, availability and integrity of ePHI as required by HIPAA. The database is fully encrypted, access to the application is encrypted, data is backed up regularly at a SAS 70 Type II certified data center, strong passwords are required and changed frequently, all actions are logged which offers a strong audit trail, powerful firewalls protect the servers, allows ability to print a paper copy of medical file, and limited IP addresses are allowed to access the service.

I make reasonable and appropriate administrative, technical, and physical safeguards for protecting ePHI. Including: (1) Ensuring the confidentiality, integrity, and availability of all ePHI that I create, receive, maintain or transmit; (2) Identifying and protecting against reasonably anticipated threats to the security or integrity of the information; (3) Protecting against reasonably anticipated, impermissible uses or disclosures; and (3) Ensuring compliance by my workforce.

A. Workstation, Device Security, and Technical Safeguards

I implement policies and procedures to specify proper use of and access to workstations and electronic media. I have policies and procedures regarding the transfer, removal, disposal, and re-use of electronic media, to ensure appropriate protection of electronic protected health information. I also have several technical safeguards to protect your health information including:

1. Access Control. I implement technical policies and procedures that allow only authorized persons to access electronic protected health information (ePHI).
2. Audit Controls. I implement hardware, software, and/or procedural mechanisms to record and examine access and other activity in information systems that contain or use ePHI.
3. Integrity Controls. I implement policies and procedures to ensure that ePHI is not improperly altered or destroyed.
4. Transmission Security. I implement technical security measures that guard against unauthorized access to ePHI that is being transmitted over an electronic network.

V. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI: You have the following rights with respect to your PHI:

1. The Right to Request Limits On Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.
2. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you at an alternate address (for example, sending information to you work address rather than your home address) or by alternate means (for example, email instead of regular mail). I must agree to your request so long as I can easily provide the PHI to you in the format you requested.
3. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI, but I know who does, I will tell you how to obtain it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

4. If you request copies of your PHI. I will charge you not more than $.25 for each page. Instead of providing you with the PHI that you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.
5. The Right to Get a List of the Disclosure I Have Made. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment or health care operations, directly to you, or to your family. The list also will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel.
6. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed, and the reasons for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.
7. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.
8. The Right to Get This Notice by Email. You have the right to get a copy of this Notice by email. Even if you have agreed to receive notice via email, you also have the right to request a paper copy or download from my website.

VI. HOW TO FILE A COMPLAINT ABOUT MY PRIVACY PRACTICES. If you think that I may have violated your privacy rights, or if you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI, below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VII. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES. If you have any questions about this Notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at Whitney Schlife, LPCC, CA Lic. Num. LPCC 2263, 43391 Business Park Dr, Suite C3, Temecula, CA 92560, (P) 951-404-5636 or email at whitney@reviveclinicalcounseling.com

NOTICE OF PRIVACY OF PRACTICES

EFFECTIVE DATE OF THIS NOTICE. This Notice went into effect on April 3, 2017.

I, _____have read and understand this Notice of Privacy Practices:

_____ _____

Client or Parent/Guardian Signature Date