

Relationship Resolutions, LLC  
P: 412-921-3908, F: 866-229-3442

969 Greentree Rd  
Pittsburgh, PA 15220

5433 Walnut St, Ste 3  
Pittsburgh, PA 15143

**CLIENT INFORMATION**

**Client Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

What led you to the decision to engage in psychotherapy at this time:

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Have you been in counseling before? \_\_\_\_\_ If so, please list approximate dates and length of attendance?

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Did you find the experience(s) helpful? \_\_\_\_\_

Why or why not?

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What do you hope to get out of your current therapy?

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How did you hear about Relationship Resolutions? \_\_\_\_\_

If online, which website or search engine:

<input type="checkbox"/> Google	<input type="checkbox"/> Super pages	<input type="checkbox"/> Psychology Today
<input type="checkbox"/> Yahoo	<input type="checkbox"/> Network Therapy	<input type="checkbox"/> Counsel Search
<input type="checkbox"/> MSN	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other
<input type="checkbox"/> Family and Marriage Counseling Directory		
<input type="checkbox"/> American Association for Marriage and Family Therapy		

What led you to the decision to seek services at Relationship Resolutions as opposed to some other Practice? \_\_\_\_\_

**IDENTIFYING INFORMATION**

Race/Ethnicity (optional): \_\_\_\_\_

Religion, if applicable: \_\_\_\_\_

Highest degree completed: \_\_\_\_\_

Major(s): \_\_\_\_\_

Do you have any plans to return to school? \_\_\_\_\_

If so, what type of schooling might you be interested in?

Current Occupation/Main Life Activity:

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

Ultimate job/life fantasy:

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

**MEDICAL / PHYSICAL HEALTH HISTORY**

Name of Primary Care Physician: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

Name of Psychiatrist, if applicable: \_\_\_\_\_

Psychiatrist's Address: \_\_\_\_\_

Psychiatrist's Phone: \_\_\_\_\_

List all current medications being taken:

1.) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_

Start Date \_\_\_\_\_ Purpose \_\_\_\_\_

2.) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_

Start Date \_\_\_\_\_ Purpose \_\_\_\_\_

3.) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_

Start Date \_\_\_\_\_ Purpose \_\_\_\_\_

4.) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_

Start Date \_\_\_\_\_ Purpose \_\_\_\_\_

Do you have any known allergies or adverse reactions? \_\_\_\_\_

If so, please list: \_\_\_\_\_

Do you have any current medical problems? \_\_\_\_\_

If so, please describe:

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

Have you ever been hospitalized for medical or psychiatric reasons (circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe the quality of your sleep at night: \_\_\_\_\_

\_\_\_\_\_

How has your appetite for food been lately? \_\_\_\_\_

Have your eating patterns or your body weight ever been a concern for you? \_\_\_\_\_

If so, please describe:

\_\_\_\_\_

\_\_\_\_\_

Describe the amount and type of physical activity or exercise that you engage in on a regular basis:

\_\_\_\_\_

\_\_\_\_\_

## **FAMILY HISTORY**

Please answer the following questions as completely as possible.

Place of birth: \_\_\_\_\_

What one word best describes your childhood?

\_\_\_\_\_

Briefly describe your relationship with your mother,

a) while growing up:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

b) now:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Briefly describe your relationship with your father,

a) while growing up:

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b) now:

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List your brothers and sisters, their ages and current state of residence:

	Name	Relationship	Age	State of Residence
A.				
B.				
C.				
D.				

Describe any significant family medical or mental health history and severity of current symptoms:

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## **RELATIONSHIP STATUS**

Please indicate your current relationship status (check all that apply):

Married

Divorced

If divorced: How many times have you been married? \_\_\_\_\_

What was the date of your most recent divorce? \_\_\_\_\_

Separated

Widowed

Never Married

Living Together

Dating More Than One Person

Dating One Person

Not Dating Anyone At the Present Time

Please add any relevant comments on the quality of your present relationship(s) or lack of relationship: \_\_\_\_\_

\_\_\_\_\_

Please indicate your current living situation:

Living Alone

Living with Spouse

Living with Spouse and Children

Living with Significant Other

Living with Roommate

Other (please describe): \_\_\_\_\_

List your spouse (or significant other), your children and their ages:

Name	Relationship	Age	Lives with
A.			
B.			
C.			
D.			

Have you ever been or are you currently being emotionally or physically abused by your partner / spouse? \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

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Do you feel safe in your current relationship? \_\_\_\_\_

Is there someone from a previous relationship who is making you feel unsafe now?  
\_\_\_\_\_ If so, whom and how? \_\_\_\_\_

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### **EMOTIONAL / MENTAL HEALTH HISTORY**

How would you rate the level of stress that you are currently experiencing on a daily basis? (1 = no stress, 10 = constant, severe stress): \_\_\_\_\_

If there is something in particular that you feel is responsible for the stress in your life at this time, please describe:

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Have you had any recent or do you have any impending losses? \_\_\_\_\_

If so, please describe: \_\_\_\_\_

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Have you ever or do you currently have suicidal or homicidal thoughts? \_\_\_\_\_

If so, please describe: \_\_\_\_\_

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Have you ever attempted suicide or homicide? \_\_\_\_\_

If so, please describe:

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Is there any family history of suicide or homicide? \_\_\_\_\_

If so, please describe:

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Please check any of the following that describes how you have been feeling lately or that you have experienced recently.

- sad  anxious  depressed  excessive fears  quality  angry  aggressive
- resentful  worthless  tearful  irritable  confused  extreme ups/downs
- jealous  hopeless  helpless  social withdrawal  difficulty with memory
- obsessions/compulsions  poor concentration  family problems  sexual abuse
- child abuse  verbal abuse  physical abuse  feelings of persecution

## **SEXUAL HISTORY**

Have any aspects of your sexuality ever been a cause of concern for you? \_\_\_\_\_

If so, please describe:

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Are you currently engaged in a sexual relationship with anyone? \_\_\_\_\_

How frequently do you have sex? \_\_\_\_\_

Do you experience any pain with intercourse? \_\_\_\_\_

How would you rate your desire for sex?      High average              low

Are you able to be and stay aroused sexually? \_\_\_\_\_

Are you able to orgasm? \_\_\_\_\_

How many sexual partners have you had in your lifetime?

Less than 5      6-10      11-20      greater than 20

Have you ever experienced sexual abuse or assault? \_\_\_\_\_ If so, please describe:

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## **SUBSTANCE ABUSE HISTORY**

### **ALCOHOL**

When was the last time you drank any alcohol? \_\_\_\_\_

How much did you drink at that time? \_\_\_\_\_

How often do you drink alcohol? \_\_\_\_\_

How much alcohol do you usually drink when you do drink? \_\_\_\_\_

Has anyone ever expressed a concern about your drinking? \_\_\_\_\_

If so, who? \_\_\_\_\_

What was their concern? \_\_\_\_\_

### **MARIJUANA**

Have you ever used marijuana? \_\_\_\_\_

If so, how often? \_\_\_\_\_

Date you last used marijuana? \_\_\_\_\_

Have you ever used any other illicit drug or abused any prescription meds? \_\_\_\_\_

If so, which ones? \_\_\_\_\_

how often? \_\_\_\_\_

Date of last use? \_\_\_\_\_

Do you have any family members or significant others who now have or once had a problem with alcohol or drugs? \_\_\_\_\_ If so, who? \_\_\_\_\_

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## **LEGAL HISTORY**

Are you currently having, or have you ever had any legal problems? \_\_\_\_\_

If so, please describe \_\_\_\_\_

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## **LIFESTYLE ASSESSMENT**

Are you currently having, or have you ever had any problems related to money, spending, gambling, credit cards or finances? \_\_\_\_\_

If so, please describe

\_\_\_\_\_

\_\_\_\_\_

How would you describe your social network of friends and acquaintances?

\_\_\_\_\_

\_\_\_\_\_

What are your favorite leisure activities?

\_\_\_\_\_

\_\_\_\_\_

Are you involved in any volunteer activities or charitable organizations? \_\_\_\_\_

If so, describe: \_\_\_\_\_

\_\_\_\_\_

## Relationship Resolutions, LLC

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Pittsburgh, PA 15232

### CLIENT CONSENT FORM

**Phone: (412) 921-3908**    [www.relationshipresolutions.org](http://www.relationshipresolutions.org)    **Fax: (866) 229-3442**

**IMPORTANT INFORMATION AND CLIENT CONSENT:** Please read and sign at the end stating you have fully read and understand the information below.

**CLIENT/THERAPIST RELATIONSHIP:** You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

**AVAILABLE SERVICES:** Relationship Resolutions offers a wide array of counseling services, including individual, family, couples, and group services. We are staffed by skilled and experienced licensed professional counselors, licensed marriage and family therapists, licensed clinical social workers, and licensed clinical psychologists. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

**RISKS AND BENEFITS:** Counseling and psychotherapy can be beneficial but there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. In the presence of these emotions, some clients start to wonder if the therapy is helping. Oftentimes, the level of distress is a necessary experience in the journey of self-discovery and change. The benefits of counseling can, therefore, far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, a reduction in maladaptive behavior, increased insight, and an increase in personal choice. While we cannot guarantee these benefits, it is our desire to work with you to attain your personal goals.

**COUNSELING:** We provide short and long-term counseling to address a variety of presenting and underlying problems which are a source of distress for our clients. Your first visit will be an assessment session in which your therapist will be gathering information to better understand your position. Your therapist will be attempting to clarify your goals for change and will offer their ideas about the way s/he can be assistance to you in achieving those goals.

The goal of is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current Therapist are not a good fit, please discuss this matter with your Therapist to determine if transferring to a more suitable Therapist is right for you. If you and your Therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs. If you are not comfortable addressing your desire to switch clinicians with your therapist, please contact the Director, Megan Norris at [megan.norris@relationshipresolutions.org](mailto:megan.norris@relationshipresolutions.org) or 412-921-3908 to discuss your situation.

All of the therapists at Relationship Resolutions are required to demonstrate cultural competence. We are aware that culture impacts a client's experiences, values, lifestyles, choices, and ways of interacting, and we strive to understand the role our client's culture plays in their life. If at any time you feel as though you are being discriminated against or treated disrespectfully based on your race, ethnicity, sexual orientation, or religious beliefs, please contact the Director, Megan Norris, to discuss your concerns.

At Relationship Resolutions, we believe that wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

**APPOINTMENTS:** Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent or longer sessions are available if determined appropriate by your Therapist. If you must cancel or reschedule your appointment, we require that you call your therapist at \_\_\_\_\_ at least 24 hours in advance, whenever possible. This will free your appointment time for another client. Failure to do so will result in a \$60 missed session fee.

<b>FEE SCHEDULE:</b>	*Diagnostic & Evaluation Session (1 <sup>st</sup> visit)	\$125-150
	*Regular Office Visits (50 minutes) (Individual/ Family Therapy)	\$100-125
	*Extended Office Visit (75 min.)	\$125-150
	Phone Consults (Over 10 min.)	\$50
	Administration of Gottman Marital Assessment	\$40
	Written Reports (disability papers, letters, legal reports)	\$40
	Returned check fee per check	\$25

*\*Fee varies by provider*

A reasonable fee will be charged for copies of any records requested by the Client. All checks are to be made out to Relationship Resolutions and not your individual provider.

**PAYMENT/INSURANCE FILING:** Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If your therapist at Relationship Resolutions is in network with your insurance company, we will file insurance claims for you, and we will honor any contractual agreements that have specific reimbursement restrictions and claim requirements. If your insurance company sends reimbursement checks directly to you, you are legally obligated to sign the checks over to the provider for services rendered. If you wish to file your own claim or if you are using out of network benefits, we expect full payment at the time of service, and we will provide you with a statement for services rendered.

**EMERGENCIES:** Relationship Resolutions is not a 24-hour crisis service. In the event of a life-threatening emergency, you need to call 911 or immediately proceed to the closest emergency room. If you are experiencing a non-life threatening emergency, please call your therapist at the number s/he gives you at today's session.

**CONFIDENTIALITY:** Relationship Resolutions follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a Client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

**CONSENT FOR EMAIL CORRESPONDENCE:** Email correspondence poses the risk, not only of your email address being visible on the Internet, but also the content of your message, and the possibility of a computer virus. Also, we cannot assure that your family members, friends, co-workers etc. are not reading the email correspondence you receive. We maintain anti-virus software on our computers and make every effort to keep your information private.

**DUTY TO WARN/DUTY TO PROTECT:** If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name

Telephone Number

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**CONSENT TO TREATMENT:** By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

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Signature – Client/Parent

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Date

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Signature – Spouse/Partner/Parent

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Date

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Therapist

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Date

I hereby authorize payment of medical benefits to be made to Relationship Resolutions, LLC for services provided to me and the release of necessary medical information for insurance reimbursement purposes.

This assignment will remain in effect until revoked by me in writing. **I understand that I am financially responsible for all charges whether or not paid by said insurance. If I need to cancel a session for any reason, the therapist requires 24 hours notice, prior to the session or I agree to pay the \$60 late cancellation / no show fee.** I also understand that if my check bounces, I will be responsible for the \$25 service fee in addition to the session fee. I hereby authorize said assignee to release any information necessary to secure payment, including use of a collection agency, as required.

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Client/Parent

---

Date

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**Client Information**

**Client Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: \_\_\_ Male \_\_\_ Female

Marital Status \_\_\_ Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Divorced/Separated

Address: \_\_\_\_\_  
Street Apt # City State Zip

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email address: \_\_\_\_\_ Referral Source: \_\_\_\_\_

Employer Name: \_\_\_\_\_

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Emergency Contact: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

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**Insurance Information**

Name of Insurance: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_

SS # of primary cardholder (if different than own): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

DOB of primary cardholder (if different than own): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer of primary cardholder (if different than own): \_\_\_\_\_

Phone number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(on back of card – usually says “For mental health / substance abuse....”)

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# RELATIONSHIP RESOLUTIONS, LLC

969 Greentree Rd.  
Pittsburgh, PA 15220

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Pittsburgh, PA 15232

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## Notice of Privacy Practices Receipt and Acknowledgment of Notice

Patient/Client Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

I hereby acknowledge that I have reviewed and have been given an opportunity to receive a copy of Relationship Resolutions' Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer, Megan Norris at 412-921-3908.

\_\_\_\_\_  
Signature of Patient/Client

\_\_\_\_\_  
Signature or Parent, Guardian or  
Personal Representative\*

\_\_\_\_\_  
Date

\* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt:

\_\_\_\_\_  
Signature of Clinician

\_\_\_\_\_  
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.**

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

#### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:**

**For Treatment.** Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members and discussion of your case at case consultation meetings. We may disclose PHI to any other consultant only with your authorization.

**For Payment.** We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations.** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and

conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

**Required by Law.** Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

**Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.**

**Abuse and Neglect  
Emergencies  
National Security**

**Judicial and Administrative Proceedings  
Law Enforcement  
Public Safety (Duty to Warn)**

**Without Authorization.** Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as state licensing boards or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Verbal Permission.** We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization.** Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

## **YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Megan Norris at Relationship Resolutions, LLC, 969 Greentree Road, Pittsburgh, PA 15220.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this Notice.

## **COMPLAINTS**

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Megan Norris, our Privacy Officer, at the address listed above, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.** **The effective date of this Notice is June 1, 2009.**