Shelda Bartels, MA, LMHC (206) 271-9371

600 Main St., Suite D, Edmonds, WA 98020
608 State Street, Ste. 130, Kirkland, WA 98033

To new clients:

This packet includes information about me and forms for you to fill out and bring with you to our first session. It is a lot of reading, but the information is important, so please review it in its entirety. If for some reason you are unable to complete the paperwork before our session I will have copies in my office and we will use your session time to complete the paperwork.

The ***Disclosure Statement*** outlines my policies regarding financial matters, confidentiality of information, and other administrative issues.

The ***Intake Form provides*** me with your basic identifying and contact information.

If you would like for me to consult with other therapists you have worked with, please complete the ***Authorization to Release Health Care Information*** form. We will discuss the possibility of my having contact with your former therapists in your initial session.

Please complete this paperwork prior to our initial meeting so we can spend our time together on your personal concerns. I look forward to meeting with you.

Shelda Bartels, MA
Licensed Mental Health Counselor
,

Checklist for completing paperwork:

- Read my **Disclosure Statement** found on pages 2-4. Each of you sign and date on page 4.
- Complete your **Intake Form** found on pages 5-6 and 7-8. Complete one form each.
- If you would like me to communicate with other health care providers about your therapy please complete page 9.
- Please read through the **Revocation of Consent** form and *only sign if applicable.*
- Read through the **Notice of Privacy Practices** regarding your therapy pages 12-14. Each of you sign that you have received the **Notice of Privacy Practices** on page 11.
- Each of you initial all pages in upper right hand corner to indicate that you have read and understand the information provided.

Initial _____

Shelda Bartels, MA, LMHC
Shelda Bartels Counseling Services
600 Main Street
Suite D
Edmonds, WA 98020

608 State Street
Suite 130
Kirkland, WA 98033

DISCLOSURE STATEMENT

Training and Degrees: I received my Master of Arts in Counseling Psychology from Mars Hill Graduate School in May 2008 now known as The Seattle School of Theology and Psychology. This program is fully accredited by the Transnational Association of Christian Colleges and Schools (TRACS), a national accrediting agency that is recognized by the Council for Higher Education Accreditation (CHEA). I practice under the title of state Licensed Mental Health Counselor (LH60152902). I consult bi monthly with other therapists

Counseling Orientation: I view the counseling process as forming an alliance with you to explore the nature of your struggles. Although we will spend much time dealing with the specific issues that brought you into counseling, we will also look at the nature of your relationships with the significant people in your life. According to my theoretical orientation, many of the dynamics that have influenced the complexity and intensity of your struggles are rooted in relational issues. I believe you are made to relate in a satisfying and self-giving manner, and this is likely both the source of your greatest joy and your deepest problems. Thus, we will explore how your relational style interferes with the enjoyment for which you are made. This is also meant to give you hope; that by dealing with the source of the problem we will address the symptoms you are experiencing as well. I believe that some issues can have a physical component. In such cases, medical consultation will be advised.

Fees: The fee for counseling is _____ per 50-minute session. Fees are adjusted annually on January 1 and will not increase more than $10 per year. Payments (cash or check) are to be made at the beginning of each session. A $25 fee will be charged for returned checks. Unpaid balances incur the maximum finance charge allowed by law after 30 days. Outstanding balances may be sent to a collection agency.

Insurance Information: You may be eligible to receive reimbursement from your insurance company for your counseling sessions. When you are negotiating with your insurance company, it might be helpful for you to know that I have a Master's degree in Counseling Psychology and I am licensed. I do not file insurance claims on your behalf. If your insurance provider will be covering the cost of your counseling, then you need to make arrangements for the insurance provider to reimburse you directly. I can provide a receipt with a procedure code and a diagnosis if necessary. You are responsible for obtaining and filling out any appropriate paperwork and submitting it to the insurance company. The initial session will be billed as an Assessment (CPT Code 90801) while subsequent sessions will be billed as Individual Psychotherapy (CPT Codes 90806 or 90808). A provisional diagnosis will be included on the bill so the insurance provider can reimburse you. This diagnosis is subject to change based on further assessment. I assume no responsibility for the continuation of confidentiality of the information once it is released to the insurance company.

Missed Appointments: In the event that you are unable to keep an appointment, please notify me via phone a minimum of 24 hours in advance. E-mail and text messages are not adequate notice. **If you miss your appointment for whatever reason and fail to give me adequate notice, you will be responsible for the full fee for the session.** If you are late, I will still stop at our regular ending time in order to keep my schedule, and you will still be required to pay for the entire session. In the event of a missed appointment, the bill will reflect a late cancellation instead of a clinical session.

Initial _____

DISCLOSURE STATEMENT

Most insurance companies will not reimburse for missed appointments. If I have an emergency, I will notify you as soon as possible of my need to reschedule our appointment.

Termination of Treatment: When you wish to terminate treatment, please give a minimum of one week's notice. You may terminate treatment at any time without moral, legal, or financial obligation beyond payment of services already rendered. It is expected that we will discuss the prospect of termination so that both parties will be clear about any details that need attention as part of the termination process. If you fail to schedule a future appointment, cancel a scheduled appointment, or fail to keep a scheduled appointment and do not contact me within 30 days of the date of last recorded contact, it will be understood that you have terminated treatment. I shall have no further obligation to you once treatment has been terminated.

Testifying in Court: If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation time, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge my full fee per hour for preparation, travel, and attendance (waiting and participation) at any legal proceeding.

Choosing a Counselor: You have the right to choose a counselor who best suits your needs and purposes. You may seek a second opinion from another mental health practitioner or may terminate therapy at any time.

Confidentiality: There is a legal privilege in this state protecting the confidentiality of the information that you share with me. As a professional, **I can assure you that I strive to maintain the strictest ethical standards of confidentiality.** For this reason, if you want me to release information about your participation in therapy to anyone, I will require you to sign the "Authorization to Release Health Care Information" form. This confidentiality has the following exceptions provided by law:

a) In the event of a medical emergency, emergency personnel or services may be given necessary information.
b) In the event of a threat to harm oneself or someone else, if that threat is perceived to be serious, the proper individuals must be contacted. This may include the individual against whom the threat is made.
c) In the event of suspected child or elder abuse, the proper authorities must be contacted. The actions do not have to be witnessed to be reported.
d) If ordered by a judge or other judicial officers, information regarding the client's treatment must be disclosed.
e) If the client brings a complaint against me with the State of Washington, Department of Health, client information will be released.
f) If an attorney in the State of Washington subpoenas records, they will be released unless the client files a Protection Order within 14 days of the subpoena.
g) In the event of the client's death or disability, information may be released if the client's personal representative or the beneficiary of an insurance policy on the client's life signs a release authorizing disclosure.
h) In the event the client reveals the contemplation or commission of a crime or harmful act, the therapist may release that information to the appropriate authorities.
i) In the case of a client who is a minor, information indicating that the client was the victim of a crime may be released to the proper authorities.

The client understands and agrees that the therapist's working notes are not considered part of the clinical record and will not be released to the client or to any other persons, agencies, or organizations under any circumstances. The client understands and agrees that any records obtained from other therapists, agencies, or institutions also will not be released by the therapist under any circumstances. The therapist will respond to any court order for records by providing only the dates of treatment or contacts with the client and a general summary of psychotherapy/counseling activity.

Initial _____

DISCLOSURE STATEMENT

The therapist will have broad discretion to release any information she deems relevant in situations where she believes the client or others to be at risk of physical harm, physical or sexual abuse, molestation, or severe neglect.

Each client has the right to refuse treatment at any time.

Consultations: I regularly consult with other professionals regarding clients with whom I am working. This allows me to gain other perspectives and ideas about how best to help you reach your goals. These consultations are conducted in such a way that confidentiality is maintained.

State Information: Therapists practicing psychotherapy for a fee must be registered or certified with the Department of Health for the protection of the public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment.

The purpose of the Counselor Credentialing Act (Chapter 18.19 RCW) is (A) To provide protection for public health and safety; and (B) To empower the citizens of the State of Washington by providing a complaint process against those counselors who commit acts of unprofessional conduct.

Unprofessional Conduct: The brochure called "Counseling or Hypnotherapy Clients" lists ways in which counselors may work in an unprofessional manner. If you suspect that my conduct has been unprofessional in any way, please contact the Department of Health at the following address and phone number:

Department of Health, Counselor Programs
P.O. Box 47869
Olympia, WA 98504-7869
360.664.9098

Kirkland: For clients who are meeting me in Kirkland:
I am a private and independent practitioner and work in association with several other independent practitioners under the heading of Eastside Christian Counseling Offices. This association exists for the purpose of sharing business expenses and does not constitute a partnership or shared therapeutic practice.

Contacting Me by Phone: You may leave me a voice message at 206 271-9371. I work to check these messages and return your call within 24 hours. Please limit your phone conversation needs to appointment scheduling and emergencies.

Emergencies: If you are in an emergency and cannot reach me, please call one of the following numbers for help: General Emergencies: 911
Crisis Clinic: 800.244.5767 or 206.461.3222 or (425) 258-4357

In addition to your signature below, please initial all pages of this document.
I have read and understand the information presented in this form.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Shelda Bartels, MA, LMHC (therapist) Date

Initial _____

Shelda Bartels Counseling Services
600 Main Street
Suite D
Edmonds, WA 98020

608 State Street
Suite 130
Kirkland, WA 98033

INTAKE FORM PART 1

Date _____ Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____

Sex (M/F) _____ Birth Date _____ SS# _____

May I contact you by email for scheduling purposes? _____

Email Address: _____

Local Phone _____ *Can I call you here?* _____ *Can I leave a message?* _____

Cell Phone _____ *Can I call you here?* _____ *Can I leave a message?* _____

I typically will not identify myself as calling about counseling when I call, in order to protect your privacy. Due to a variety of factors, sometimes peoples are difficult to reach or never receive messages. Please call me back if you do not hear from me in a reasonable time.

How did you hear about me? _____ Has anyone urged you to come here? _____

Briefly tell me about the concerns that have brought you here.

_____

_____

_____

Please check any current or past issues that still affect you.

- ❑ Eating Disorders
- ❑ Academic Issues
- ❑ Childhood Abuse *(i.e. physical, sexual, emotional)*
- ❑ Stress/Anxiety
- ❑ Phobias *(type: _____)*
- ❑ Alcohol/Other Drug Use
- ❑ Sexual Assault/Rape
  - o *recently (when: _____)*
  - o *in the past*
- ❑ Death of a someone close
  - o *recently (when: _____)*
  - o *in the past*
- ❑ Family Issues *(i.e. divorce, alcoholism, domestic violence)*
- ❑ Other: _____
- ❑ Pregnancy Issues
- ❑ Spiritual Concerns
- ❑ Depression
- ❑ Pornography
- ❑ Sexual Identity Issues
- ❑ Relationship Concerns
  - o *Family*
  - o *Friend*
  - o *Parent*
  - o *significant other*
  - o *recently (when: _____)*
  - o *roommate*
  - o other: _____
- ❑ Suicidal Thoughts

Initial _____

INTAKE FORM PART 2

Your History

Current medical problems _____
Current medications *(all, including herbal)* _____
Are you currently working with any Personal Physician? _____ Phone Number: _____
Name _____What for? _____
Have you been on any medications in the past for mental health issues? _____
(Please list) _____

Have you previously seen a therapist? _____ Who/Where? _____
How long ago? _____ For what types of issues? _____
Are you currently seeing a therapist? _____

Have you ever been hospitalized for physical or mental health issues? *(Briefly describe)*

_____

Have you had any previous suicide attempts? _____ *(Briefly describe)*_____

_____

If you currently experience any of the following symptoms, please rate them using the key below.

Never = 0 Seldom =1 Often = 2 Always = 3

____ Difficulty concentrating
____ Crying
____ Missing classes
____ Feeling helpless
____ Feeling uptight
____ Worrying
____ Feeling hopeless
____ Feeling afraid
____ Lying to others
____ Feeling out of control
____ Feelings of self-doubt
____ Injuring self
____ Nervous around others
____ Suicidal Thoughts

_____ Memory loss or blackout
_____ Difficulty sleeping
_____ Stealing
_____ Anger
_____ Eating binges
_____ Drinking heavily
_____ Other drug use
_____ Guilt feelings
_____ Withdrawing socially
_____ Sexual preoccupation
_____ Physical symptoms *(i.e. headaches, digestive)*
List: _____
Have you seen a health care provider for these?
Other_____

Please use the scale below to answer the following questions.

4=True to a great extent 3=Mostly true 2=Somewhat true 1=Not at all true

My current concerns affect my success in life. _____
My current concerns affect my ability to interact and connect with others. _____
I am optimistic that I will be able to make some positive changes as a result of counseling. _____

Initial _____

Shelda Bartels Counseling Services
Shelda Bartels, MA
600 Main Street
Suite D
Edmonds, WA 98020

608 State Street
Suite 130
Kirkland, WA 98033

INTAKE FORM PART 1

Date _____ Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____

Sex (M/F) _____ Birth Date _____ SS# _____

May I contact you by email for scheduling purposes? _____

Email Address: _____

Local Phone _____ *Can I call you here?* _____ *Can I leave a message?* _____

Cell Phone _____ *Can I call you here?* _____ *Can I leave a message?* _____

I typically will not identify myself as calling from Shelda Bartels Counseling when I call, in order to protect your privacy. Due to a variety of factors, sometimes peoples are difficult to reach or never receive messages. Please call me back if you do not hear from me in a reasonable time.

How did you hear about me? _____ Has anyone urged you to come here? _____

Briefly tell us about the concerns that have brought you here.

_____

_____

Please check any current or past issues that still affect you.

- ❑ Eating Disorders
- ❑ Academic Issues
- ❑ Childhood Abuse *(i.e. physical, sexual, emotional)*
- ❑ Stress/Anxiety
- ❑ Phobias *(type: _____)*
- ❑ Alcohol/Other Drug Use
- ❑ Sexual Assault/Rape
  - o *recently (when: _____)*
  - o *in the past*
- ❑ Death of a someone close
  - o *recently (when: _____)*
  - o *in the past*
- ❑ Family Issues *(i.e. divorce, alcoholism, domestic violence)*
- ❑ Other: _____
- ❑ Pregnancy Issues
- ❑ Spiritual Concerns
- ❑ Depression
- ❑ Pornography
- ❑ Sexual Identity Issues
- ❑ Relationship Concerns
  - o *Family*
  - o *Friend*
  - o *Parent*
  - o *Significant other*
  - o *recently (when: _____)*
  - o *roommate*
  - o other: _____
- ❑ Suicidal Thoughts

Initial _____

INTAKE FORM PART 2

Your History

Current medical problems _____
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Are you currently working with any Personal Physician? _____ Phone Number: _____
Name _____What for? _____
Have you been on any medications in the past for mental health issues? _____
(Please list) _____

Have you previously seen a therapist? _____ Who/Where? _____
How long ago? _____ For what types of issues? _____
Are you currently seeing a therapist? _____

Have you ever been hospitalized for physical or mental health issues? *(Briefly describe)*

_____

Have you had any previous suicide attempts? _____ *(Briefly describe)*_____

_____

If you currently experience any of the following symptoms, please rate them using the key below.

Never = 0 Seldom =1 Often = 2 Always = 3

____ Difficulty concentrating
____ Crying
____ Missing classes
____ Feeling helpless
____ Feeling uptight
____ Worrying
____ Feeling hopeless
____ Feeling afraid
____ Lying to others
____ Feeling out of control
____ Feelings of self-doubt
____ Injuring self
____ Nervous around others
____ Suicidal Thoughts

____ Memory loss or blackout
____ Difficulty sleeping
____ Stealing
____ Anger
____ Eating binges
____ Drinking heavily
____ Other drug use
____ Guilt feelings
____ Withdrawing socially
____ Sexual preoccupation
____ Physical symptoms *(i.e. headaches, digestive)*
List: _____
Have you seen a health care provider for these?
Other_____

Would you be interested in a counseling group? _____ For what issues/topics? _____

Please use the scale below to answer the following questions.

4=True to a great extent 3=Mostly true 2=Somewhat true 1=Not at all true

My current concerns affect my success in life. _____
My current concerns affect my ability to interact and connect with others. _____
I am optimistic that I will be able to make some positive changes as a result of counseling. _____

Initial _____

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Shelda Bartels, MA, LMHC 206 271-9371

Bartels Counseling Services – 600 Main Street, Ste. D, Edmonds, WA 98020

608 State Street, Ste. 130, Kirkland, WA 98033

I, _____, hereby give my consent for Shelda Bartels, LMHC to:

☐ Release Information ☐ Exchange Information

☐ Obtain Information ☐ Other

To/with/from:

Name:_____

Address:_____

Phone:_____

Description of information to be released: _____

_____

_____

Purpose of disclosure:_____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus) sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

Signature of Client _____ Date_____

Printed Name of Client _____

This authorization will expire in 90 days after the termination of therapy or on_____as specified by the client and may be revoked at any time by providing a written request of revocation of this release.

Therapist Signature: _____ Date_____

Printed Name of Therapist: Shelda M. Bartels_____

CONFIDENTIAL

REVOCATION OF CONSENT
FOR USE AND DISCLOSURE OF HEALTH CARE INFORMATION

Client Name: _____ Date of Birth: _____

SSN: _____ Previous Name _____

I no longer want Shelda Bartels, MA to use and disclose health care information about me for treatment, billing and payment, and health care operations.

I understand that:

- This request only applies after I sign the document.
- Shelda Bartels, MA, may have already taken action based upon my earlier permission.
- Shelda Bartels, MA, is allowed by law to use and disclose my health care information to complete treatment, billing and payment, and health care operations already in progress. I agreed to this when I signed the "Consent for Use and Disclosure of Health Care Information" or the "Acknowledgement of Receipt of Notice of Privacy Practices".
- Shelda Bartels, MA, is allowed or required by law to release health care information without my permission under certain situations.
- Shelda Bartels, MA, does not have to provide any further health care services to me.

_____ _____

Signature of Client or Legally Authorized Individual Date

_____

Relationship to client if signed on behalf of the patient by parent, legal guardian, personal representative, etc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for Shelda Bartels, MA.

Signature of Client *(or Legal Guardian):* _____ Date: _____

Signature of Client *(or Legal Guardian):* _____ Date: _____

If a personal representative signs this acknowledgement on behalf of the client, please complete the following:

Name of Personal Representative: _____

Relationship to Client: _____

FOR OFFICE USE ONLY

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other *(Please specify)*

_____

This form is educational only. It does not constitute legal advice, and covers only federal, not state, law.

Initial _____

Shelda Bartels, MA

NOTICE OF PRIVACY PRACTICES INTRODUCTION

The privacy of your health information is important to me. I will not disclose your health information to others unless you tell me to do so, or unless the law authorizes or requires me to do so.

A new federal law, the Health Insurance Portability and Accountability Act, commonly known as HIPAA, requires that I inform you about how I may use information that is gathered in order to provide health care services to you. As part of this process, I am required to provide you with the attached Notice of Privacy Practices and to request that you sign an acknowledgement that you received it. The Notice describes how I may use and disclose your protected health information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. This Notice also describes your rights regarding the health information I maintain about you and a brief description of how you may exercise these rights.

Shelda Bartels, MA

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 IT CAREFULLY

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information (also called "Protected Health Information" or "PHI"). I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

A. PERMISSIBLE USES AND DISCLOSURES WITHOUT YOUR WRITTEN AUTHORIZATION

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for the purposes described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. **TREATMENT**: I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling services to you. In addition, I may disclose PHI to other health care providers involved in your treatment.
2. **PAYMENT:** I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health insurance provider. For example, I may disclose PHI to enable your health insurance provider to take certain actions before it approves or pays for treatment services.
3. **HEALTH CARE OPERATIONS:** I may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, and licensing or credentialing activities.
4. **REQUIRED OR PERMITTED BY LAW:** I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; disclosures to health and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions, or otherwise as authorized by law.

B. USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

1. **PSYCHOTHERAPY NOTES:** My notes documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by me and will not otherwise be used or disclosed without your written authorization.
2. **MARKETING COMMUNICATIONS:** I will not use your health information for marketing communications without your written authorization.
3. **OTHER USES AND DISCLOSURES:** Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

Initial _____

II. YOUR INDIVIDUAL RIGHTS

A. RIGHT TO INSPECT AND COPY.
You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under some circumstances, I may deny access to your records. I may charge a fee for the cost of copying and sending you any records requested. *[Note: State law may regulate such charges.]* If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you. *[Note: Examples should be included consistent with state law (e.g., records related to mental health, drug treatment, or family planning services).*
B. RIGHT TO ALTERNATIVE COMMUNICATIONS. You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.
C. RIGHT TO REQUEST RESTRICTIONS. You have the right to request a restriction on PHI used for disclosure for treatment, payment, or health care operations. You must request any such restriction in writing addressed to me as indicated below. I am not required to agree to any such restriction you may request.
D. RIGHT TO ACCOUNTING OF DISCLOSURES. Upon written request, you may obtain an accounting of certain disclosures of PHI made by me. This right applies to disclosures for purposes other than treatment, payment, or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.
E. RIGHT TO REQUEST AMENDMENT. You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.
F. RIGHT TO OBTAIN NOTICE. You have the right to obtain a paper copy of this Notice by submitting a request to me at any time.
G. QUESTIONS AND COMPLAINTS. If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact me. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the director or myself.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. EFFECTIVE DATE. This Notice is effective on April 14, 2003.
B. CHANGES TO THIS NOTICE. I may change the terms of this Notice at any time. If I change this Notice, I may make the new Notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new Notice. You may also obtain any revised Notice by contacting me.