STEVEN I. COOPER, LCSW-R COUNSELING AND PSYCHOTHERAPY

1169 PITTSFORD-VICTOR RD, #145, PITTSFORD, NY 14534 PHONE: 585-235-7466
WEB: WWW.COOPERCOUNSELING.COM FAX: 585-424-3614

Dear :

Welcome to my counseling practice. Attached are some forms that I ask my clients to complete at the initial session. I'd appreciate if you would fill out ALL of these forms, and sign where indicated. The copies underneath that are stapled together are for you. I will be glad to discuss any questions you might have about them.

If you have the type of health insurance that needs an insurance prior authorization, please call your primary care physician today and ask that a referral be done, and effective for today's date. If you prefer not to use your health insurance, just let me know and I'll be glad to discuss self-payment with you.

Please have your health insurance card(s) out so I can make a copy.

Please obtain this information and let me know

Call your insurance company and ask them:

1) What is my co-pay or co-insurance for outpatient mental health services?
2) Does your insurer cover & manage the mental health benefit or is it outsourced to a different insurance company?
3) Is there a deductible on this plan, and if so, how much have I already met?

Thanks for your patience and cooperation with the paperwork, and I will be with you in a few minutes

STEVEN I. COOPER, LCSW-R COUNSELING AND PSYCHOTHERAPY

1169 Pittsford-Victor Rd, #145, Pittsford, NY 14534 Phone: 585-235-7466
WEB: WWW.COOPERCOUNSELING.COM Fax: 585-424-3614

1) Welcome to my Counseling and Psychotherapy practice. I am a New York State Licensed Certified Social Worker (LCSW) whose graduate training is in the field of mental health, counseling, and psychotherapy. I am a member of the Academy of Certified Social Workers (ACSW), and have experience working with the full range of adult Psychiatric disorders. My practice is currently limited to working with adults as individuals or couples.

2) I expect that our work together will be helpful for you. However, therapy does not always accomplish everything a patient expects or hopes for. The best outcomes occur if you are on time, committed to the work, open and honest, and feel comfortable with the counselor. Please discuss with me any problems you are having with treatment. If, during the course of our work together, it appears that medications would be a helpful adjunct to your counseling, I will refer you to your Physician or a Psychiatrist for a consultation. We can discuss this further if the need arises.

3) Often your medical insurance will cover a percentage of the cost of counseling or psychotherapy. However, it is important to note that my fee is an agreement between you and me, not between me and your insurance company. You are responsible for knowing and tracking your benefits, insurance deductibles, the number of visits allowed, used, and remaining. If you have a managed care insurer, for whom I am a provider, your responsibility extends as far as the co-pay, your portion of the fee not covered by your insurer. Please note, I am not authorized to accept Workers Compensation. If your insurer denies coverage, or if you have exhausted your benefits, I reserve the right to charge you the full private fee of $120 per session.

4) Payment is expected at the time of each visit unless we agree in writing, to other arrangements. I will provide you with monthly statements for your records and insurance company on request. Unpaid balances after 30 days will accrue interest at the rate of 1% per month until paid in full. There will be charge up to $35 added to your bill for each check returned to me unpaid and to accounts submitted to collection agencies. Unfortunately, I have been forced to send a few patient accounts to collection because after, repeated requests to pay their bill, these patients have defaulted on their payment obligation. In the unlikely event that this happens, you will be responsible for the collection agencies cost, court costs, and legal feels, including reasonable attorney fees, incurred in pursuing payment in full. There is also a separate charge for letters to the court, probation, lawyers, court appearances and any documentation or telephone calls requested by insurance companies. You will be charged $150/hour prorated, and $.75 a page copying charge for these services.

5) If you are unable to keep a scheduled appointment. kindly give me twenty four hours notice. **Please note that your insurance does not cover failed appointments, and that you will be charged full fee ($120) for time reserved if you cancel in less than twenty four hours, and for missed appointments for any reason.** Any charge rendered in connection with missed appointments or late cancellations which I voluntarily choose to waive, may be reinstated in the event of subsequent missed appointments or late cancellations or if your account is submitted for collection at any future date.

6) I check in with my voice mail periodically when out of the office. If you are having a difficult time, please feel free to call and I will get back to you as soon as possible. I will presume that any phone numbers or eMail addresses you give me also represents your permission for me to use them to contact you and leave written, verbal or text messages unless you specifically instruct me otherwise in writing. My voice mail also gives instructions on how to reach me, or whomever is covering for me, in an urgent situation. If you feel this is an emergency situation that cannot wait until I return your call, please call 911 or go to a hospital psychiatric emergency department for an evaluation and ask the mental health officer on duty to reach me.

"**I have read the above and agree to its terms**"

X

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Witness Date

STEVEN I. COOPER, LCSW-R COUNSELING AND PSYCHOTHERAPY
. . .
1169 Pittsford-Victor Rd, #145, Pittsford, NY 14534 Phone: 585-235-7466
WEB: WWW.COOPERCOUNSELING.COM Fax: 585-424-3614

Release of Confidential Information to a Third-Party Payor

Please complete this if you are going to use your insurance benefits

I, authorize Steven I. Cooper, LCSW-R to disclose any necessary information to _____ for the purpose of benefit reimbursement and approval of services. The designated information may be transmitted by fax, electronic mail, other electronic file transfer mechanisms, or by telephone. This request and authorization to release information is based upon my understanding of the specific items of information to be released, my understanding of the use of the information but qualified mental health professionals once it is released, and my understanding that the source providing this information cannot be responsible for the protection of my privacy once the information is conveyed. The source is released from any and all liability resulting from the release of the information. I understand that I am not required by law to grant this release of information and I can choose to assume responsibility for payments of my own treatment. I understand that the recipient of the requested information is prohibited by federal law from making any further disclosure of it without my written permission.

I authorize payments of my health benefits to: Steven I. Cooper, LCSW-R

This consent is subject to revocation at any time except to the extent that the person instructed to make the disclosure has already taken action in reliance on it.

Signature of Client: _____, Date:

Name of Client: _____
(please print)

Signature of parent/legal guardian: _____, Date:

STEVEN I. COOPER, LCSW-R COUNSELING AND PSYCHOTHERAPY

. . .

1169 Pittsford-Victor Rd, #145, Pittsford, NY 14534 Phone: 585-235-7466
WEB: WWW.COOPERCOUNSELING.COM Fax: 585-424-3614

	FOR YOURSELF	FOR YOUR SPOUSE/PARTNER
Name:		
Street Address		
City, State, Zip:		
Phone (h): ok to use? ❑		
Phone (w): ok to use? ❑		
Cell Phone#: ok to use? ❑		
eMail Address: ok to use? ❑		
Birth date:		
Social Security Number:		
Health Insurance:		
Subscriber/Contract Number:	(Please include pre/ix letters, main #, and suf/ix #'s, i.e. YMB1234F4567-01)	(Please include pre/ix letters, main #, and suf/ix #'s, i.e. YMB1234F4567-01)
Employer:		
Occupation:		
Personal Physician (PCP):		
Taking what medications: (please list)		
Medical Surgical Problems:		
Allergies? (please list)		
Smoke Cigarettes?	YES -------- NO (Circle One)	YES -------- NO (Circle One)
Names/Ages of Children in Household		
Person (s) to contact in emergency: Names: Phones:		
Name of person who referred me:		

STEVEN I. COOPER, LCSW-R COUNSELING AND PSYCHOTHERAPY

1169 Pittsford-Victor Rd, #145, Pittsford, NY 14534 Phone: 585-235-7466
WEB: WWW.COOPERCOUNSELING.COM Fax: 585-424-3614

Authorization to Use/Disclose/Obtain Health Information

I, _____ **Enter your name, address**
(print name) (address) (phone number)

give permission for use, disclosure and/or exchange of:

Mental Health/Psychiatric: ® Alcohol/Drug: ❑ Medical/Surgical: ❑

information regarding: _____ **Enter your name & DOB**
(patient name) (date of birth)

This information may be: released to: ® Received from ❑ used by ❑

Name: _____ **Enter your Doctors Name**

Address: _____ **Enter your Doctors Addr.**

Phone #: _____ **Enter your Doctors Phone**

Purpose and need for use or disclosure

- ☒ Treatment
- ❑ Education
- ❑ Housing
- ❑ Disability Determination
- ❑ Legal Services
- ❑ Other

This information may be released by:

- ☒ Written
- ☒ Fax
- ❑ Court Testimony
- ☒ Verbal Exchange
- ❑ Electronic Information Exchange
- ❑ Other

Information to be used or disclosed shall include:

- ❑ Assessments
- ❑ Treatment Plans
- ❑ Progress Reports
- ❑ History and Physical
- ❑ Medical Information
- ❑ Lab Test Results
- ❑ Discharge Summaries
- ❑ Other
- ☒ All
- ❑ Psychiatric Information

I hereby declare that I am the ☒ Patient, ❑ Parent, ❑ Legal Guardian/Representative:

Signature & Date

_____
(patient signature) (date)

_____
(parent/guardian/significant other) (date)

_____
(Witness) (date)

This authorization shall expire:
- ❑ One year from date of authorization
- ❑ 90 days from date of authorization
- ☒ Other: expires 1 year p/care is ended

I understand that any health information disclosed pursuant to this authorization to any individual or entity that is not subject to State and Federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by State or Federal privacy laws and regulations. I also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it. To revoke this authorization, I must send written notification of my intent to revoke to Steven I. Cooper, LCSW. I understand that my treatment will not be conditioned upon my execution of this authorization unless the treatment being provided is research related and the health information is to be used for that research or the health care is being provided solely for the purpose of providing health information to a third party.

STEVEN I. COOPER, LCSW-R COUNSELING AND PSYCHOTHERAPY

. . .

1169 Pittsford-Victor Rd, #145, Pittsford, NY 14534 Phone: 585-235-7466
WEB: WWW.COOPERCOUNSELING.COM Fax: 585-424-3614

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Patient/Client Name: _____

DOB: ____/_____/_____

SSN: ____-___-_____

I hereby acknowledge that I have received a copy of Steven I. Cooper, LCSW-R, Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Steven I. Cooper, LCSW-R.

X_____
Signature of Patient/Client Date

_____
Signature of 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.)

- - - - - - - - - - - - - - - -

□ I delivered, or attempted to deliver, a copy of my Notice of Privacy Practices to the above referenced patient on _____. The patient refused to acknowledge the receipt of such Notice of Privacy Practices because:

_____
Signature of Staff Member Date

STEVEN I. COOPER, LCSW-R COUNSELING AND PSYCHOTHERAPY

1169 Pittsford-Victor Rd, #145, Pittsford, NY 14534 Phone: 585-235-7466
WEB: WWW.COOPERCOUNSELING.COM Fax: 585-424-3614

These attached stapled pages are your copies of the office/billing policies and the Federal HIPAA regulations.

STEVEN I. COOPER, LCSW-R COUNSELING AND PSYCHOTHERAPY

1169 Pittsford-Victor Road, #145, Pittsford, NY 14534 PHONE: 585-235-7466
WEB: WWW.COOPERCOUNSELING.COM Fax: 585-424-3614

1) Welcome to my Counseling and Psychotherapy practice. I am a New York State Licensed Certified Social Worker (LCSW) whose graduate training is in the field of mental health, counseling, and psychotherapy. I am a member of the Academy of Certified Social Workers (ACSW), and have experience working with the full range of adult Psychiatric disorders. My practice is currently limited to working with adults as individuals or couples.

2) I expect that our work together will be helpful for you. However, therapy does not always accomplish everything a patient expects or hopes for. The best outcomes occur if you are on time, committed to the work, open and honest, and feel comfortable with the counselor. Please discuss with me any problems you are having with treatment. If, during the course of our work together, it appears that medications would be a helpful adjunct to your counseling, I will refer you to your Physician or a Psychiatrist for a consultation. We can discuss this further if the need arises.

3) Often your medical insurance will cover a percentage of the cost of counseling or psychotherapy. However, it is important to note that my fee is an agreement between you and me, not between me and your insurance company. You are responsible for knowing and tracking your benefits, insurance deductibles, the number of visits allowed, used, and remaining. If you have a managed care insurer, for whom I am a provider, your responsibility extends as far as the co-pay, your portion of the fee not covered by your insurer. Please note, I am not authorized to accept Workers Compensation. If your insurer denies coverage, or if you have exhausted your benefits, I reserve the right to charge you the full private fee of $120 per session.

4) Payment is expected at the time of each visit unless we agree in writing, to other arrangements. I will provide you with monthly statements for your records and insurance company on request. Unpaid balances after 30 days will accrue interest at the rate of 1% per month until paid in full. There will be charge up to $35 added to your bill for each check returned to me unpaid and to accounts submitted to collection agencies. Unfortunately, I have been forced to send a few patient accounts to collection because after, repeated requests to pay their bill, these patients have defaulted on their payment obligation. In the unlikely event that this happens, you will be responsible for the collection agencies cost, court costs, and legal feels, including reasonable attorney fees, incurred in pursuing payment in full. There is also a separate charge for letters to the court, probation, lawyers, court appearances and any documentation or telephone calls requested by insurance companies. You will be charged $150/hour prorated, and $.75 a page copying charge for these services.

5) If you are unable to keep a scheduled appointment. kindly give me twenty four hours notice. **Please note that your insurance does not cover failed appointments, and that you will be charged full fee ($120) for time reserved if you cancel in less than twenty four hours, and for missed appointments for any reason.** Any charge rendered in connection with missed appointments or late cancellations which I voluntarily choose to waive, may be reinstated in the event of subsequent missed appointments or late cancellations or if your account is submitted for collection at any future date.

6)I check in with my voice mail periodically when out of the office. If you are having a difficult time, please feel free to call and I will get back to you as soon as possible. I will presume that any phone numbers or eMail addresses you give me also represents your permission for me to use them to contact you and leave written, verbal or text messages unless you specifically instruct me otherwise in writing. My voice mail also gives instructions on how to reach me, or whomever is covering for me, in an urgent situation. If you feel this is an emergency situation that cannot wait until I return your call, please call 911 or go to a hospital psychiatric emergency department for an evaluation and ask the mental health officer on duty to reach me.

"**I have read the above and agree to its terms**"

X

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Witness Date

---CLIENT COPY---

STEVEN I. COOPER, LCSW-R COUNSELING AND PSYCHOTHERAPY

. . .

1169 Pittsford-Victor Rd, #145, Pittsford, NY 14534 Phone: 585-235-7466
WEB: WWW.COOPERCOUNSELING.COM Fax: 585-424-3614

NOTICE OF PRIVACY PRACTICES

Effective as of 9/23/13

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.

If you have questions or wish to receive additional information about the about the matters covered by this Notice of Privacy Practices, please contact me at (585)235-7466.

My Duties

I am required by Law to maintain the privacy of your medical information and to provide you with notice of my legal duties and privacy practices with respect to medical information. Your medical information consists of all individually identifiable information that is created or received by me and which relates to your past, present or future physical or mental health, the provision of health care to you, or the past, present or future payment for health care provided to you. I am required to abide by the terms of this Notice of Privacy Practices as it is currently in effect.

Changes to this Notice of Privacy Practices

I reserve the right to change the terms of this Notice of Privacy Practices at any time. Any revised Notice of Privacy Practices will apply to all of the medical information that I maintain. If I materially change this Notice of Privacy Practices, I will provide to you a copy of the revised Notice of Privacy Practices at your first appointment after this Notice of Privacy Practices is changed.

Permitted Uses and Disclosures

I may use and disclose your medical information in the ordinary course of my business. I have described some of the uses and disclosures of your medical information I may undertake without your consent or authorization in the following paragraphs:

Treatment: I will use and disclose your medical information to provide, coordinate and manage your care and related services by me and other health care providers, including consulting with other health care providers about your care and referring you to another health care provider for treatment. For example, I may provide your doctor or other health care provider with the results of the counseling/ mental health evaluation. Additionally, I may contact you before the appointment to remind you of your appointment or to talk with you about preparing for the appointment. I normally will call you at the contact numbers you provide me. I may also use the email address that you provide me unless you ask me not to in writing. If you are not available or your voice mail answers, I will leave a brief message reminding you of the place and time of your appointment. If applicable, I may ask you to call me regarding your exam preparations. I may also use and disclose your medical information to inform you about treatment alternatives and about health---related benefits and services that I believe may be of interest to you.

1169 Pittsford-Victor Rd, #145, Pittsford, NY 14534 Phone: 585-235-7466
WEB: WWW.COOPERCOUNSELING.COM Fax: 585-424-3614

Payment: I will use and disclose your medical information, as needed, to obtain payment for the care that I provide to you. For example, I will bill your insurance company, you directly, or another person that may be responsible for payment of your account. I may need to contact your health plan to see if it will pay for the appointment you or your doctor has requested. Throughout this process, I may have to release details of your treatment if your health plan or other payor requires this information to make payment.

Health Care Operations: I use medical information to conduct my normal business operations. I routinely review counseling records to maintain quality assurance goals, including permitting review of my records by another therapist. In addition, I may use specific patient information to demonstrate my skills to an accreditation body. Accreditation is important to my patients and me because the process causes me to demonstrate some degree of proficiency in conducting counseling.

I may share your medical information with third party "business associates" that perform various activities (e.g., billing, transcription services or collection services) for my office. Whenever an arrangement between my office and a business associate involves the use or disclosure of your medical information, we will have a written contract that contains terms that will protect the privacy of your medical information.

Others Involved in Your Care: Unless you object, I may disclose medical information about you to family members, other relatives, close personal friends or any other person identified by your medical information if your medical information relates to that person's involvement in your care. I may also use or disclose medical information that relates to your location, general condition or death to a person responsible for your care. If the opportunity to agree or object to any such disclosure cannot be provided due to emergency circumstances, I will make the disclosure if I believe it to be in your best interests. Additionally, I may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Disclosures Required by Law: I may use or disclose your medical information when required to do so by federal, state, or local Law.

Public Health Activities: I may disclose your medical information to a public health agency for certain purposes. For example, I might contact the Food and Drug Administration (FDA) if you experience an adverse effect from any medications or I may disclose your medical information for purposes of reporting child abuse or neglect.

Victims of Abuse, Neglect, or Domestic Violence: Under certain circumstances, I may be required to disclose your medical information to a governmental authority if I feel that you have been abused or neglected or I suspect abuse or neglect of a child or elderly person.

Health Oversight Activities: I may be required to disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, or other activities necessary for the oversight of the health care system, government benefit program including Medicare.

Judicial and Administrative Proceedings: I may have to disclose your medical information if I receive an order from a court or administrative tribunal, a subpoena, discovery request or other lawful process.

Law Enforcement: I may disclose your medical information to a law enforcement official for certain law enforcement purposes, including a criminal investigation by a federal or state law enforcement agency.

1169 Pittsford-Victor Rd, #145, Pittsford, NY 14534 Phone: 585-235-7466
WEB: WWW.COOPERCOUNSELING.COM Fax: 585-424-3614

Incidental Disclosures: Disclosures of your information may occur during or as an unavoidable result of a permissible use or disclosure of your medical information. For example, during the course of your visit, other clients in the area may see or overhear discussion of your health information.

Serious Threats of Health or Safety: I may be required to disclose your medical information if, in my opinion, doing so will help avert or Lessen a serious threat to the public or yourself or the information may be necessary to apprehend an individual.

Military Personnel: If you are a member of the United States or foreign armed forces, I may disclose your medical information to the appropriate command authorities.

Inmates: I may disclose your medical information to a correctional institution or Law enforcement official having lawful custody of you if the correctional institution or Law enforcement agency represents that the information is necessary for certain purposes.

Other Rules Governing the Disclosure of Mental Health, Chemical Dependency and HIV--Related Information: Uses and disclosures of mental health treatment records, drug and alcohol abuse records and/or HIV related information that may be made without a valid authorization are materially Limited, and in some cases prohibited, by applicable New York Law and/or federal regulations. In those instances, I will comply with provisions of the more protective Law or regulation because your privacy rights are expanded under those more stringent standards. The person or entity receiving any mental health, chemical drug and alcohol abuse or HIV-related information pursuant to any of these permitted uses or disclosures is required to maintain the confidentiality of the information received.

Mental Health and Drug and Alcohol Treatment Information: Without your authorization, I may use and disclose your mental health and/or drug and alcohol treatment information under the following circumstances or to the following people or entities:

- *Pursuant to an Order of a court requiring disclosure;*
- *To the Mental Hygiene Legal Service or to an attorney representing your interest in a proceeding in which involuntary hospitalization is at issue;*
- *To the Commission on Quality of Care for the mentally disabled;*
- *To the Medical Review Board of the State Commission of Correction;*
- *To an individual and a Law enforcement agency when you present a serious and imminent danger to that individual;*
- *To the State Board for Professional Medical Conduct or the Office of Professional Discipline;*
- *With the consent of the Commissioner of Mental Health, to: (i) various governmental agencies; (ii) insurance companies requiring information necessary for payment; (iii) persons or agencies needing information to Locate missing persons; (iv) governmental agencies in connection with criminal investigations; (v) qualified researchers; (vi) a coroner or a medical examiner; (vii) a District Attorney when such request is necessary to conduct a criminal investigation relating to patient abuse; or (viii) appropriate persons and entities when necessary to prevent imminent serious harm to you or another person;*
- *To a correctional facility at which you are an inmate;*
- *To a person otherwise qualified under New York Law;*
- *To a Director of Community Services; and*
- *To the State Division of Criminal Justice Services for the sole purpose of providing, facilitating, evaluating or auditing access by the Commissioner of Mental Health.*

1169 Pittsford-Victor Rd, #145, Pittsford, NY 14534 Phone: 585-235-7466
WEB: WWW.COOPERCOUNSELING.COM Fax: 585-424-3614

HIV--Related Information: *Without your authorization, I may use and disclose your HIV-related information to the following people or entities:*

- *To an agent or employee of a health facility or health care provider under certain circumstances, including when the information is necessary to care for you, your child or one of your contacts;*
- *To a federal, state, county or local health officer when such disclosure is mandated by federal or state law;*
- *To third-party payers and insurance institutions, under certain circumstances, in order to receive payment for your care.*

Worker's Compensation: *I may disclose your medical information to comply with Laws regarding worker's compensation.*

Other Uses of Medical Information Needing an Authorization: *Any use or disclosure of your medical information that is not described above will only be made with your written authorization. For example, most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, including subsidized treatment communications, and disclosures that constitute a sale of protected health information require your written authorization. You have the right to revoke your authorization at any time, except to the extent that I have already relied on your authorization to disclose your medical information.*

Patient Rights

You have certain rights with respect to your medical information:

Requesting Restrictions: *You may ask me to limit the medical information that I use or disclose in carrying out treatment, payment or healthcare operations. I am not required to agree to your request. However, I must agree to your request to restrict disclosures of your medical information to a health plan if the disclosure is for the purposes of obtaining payment for your health care and is not otherwise required by law and I have been paid in full for the treatment I provided related to the medical information you have asked me not to disclose. If I agree to your request, I will abide by your request except as required by Law, in emergencies, or when the information is necessary to treat you. Your request must: 1) be in writing 2) describe the information that you want restricted, 3) state if the restriction is to Limit my use or disclosure, and 4) state to whom the restriction applies. You may revoke your restriction at any time by contacting me. I may ask to reschedule your appointment while I consider your request, but I will not ask you why you are requesting the restriction.*

Confidential Communications: *You may ask that I communicate with you in a particular way, or at a certain Location, to maintain the confidentiality of your medical information. Your request must be in writing, telling me how you intend to satisfy your financial responsibility, and specifying an alternate way that I can contact you confidentially. You do not have to give me a reason for your request. In certain circumstances, I may require payment in full at the time you have your appointment. You may revoke your request at any time by contacting me. I may ask to reschedule your appointment while I consider your request.*

Inspect and Copy: *You may request access to inspect and copy your medical information maintained in my records, including medical and billing records. If the requested medical information is maintained electronically and you request an electronic copy, I will provide access in an electronic format, if it is readily producible, or if not, in a readable electronic form and format mutually agreed upon. You may not inspect a copy of psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding, or information which I am otherwise prohibited from disclosing under Law. Your request must be in writing. I will act on your request for copies within 30 days after it is received by me. I will act on your request to inspect your records within*

1169 Pittsford-Victor Rd, #145, Pittsford, NY 14534 Phone: 585-235-7466
WEB: WWW.COOPERCOUNSELING.COM Fax: 585-424-3614

10 days of receipt of the request. If I deny your request, I will send you a written denial. If this happens, you may request a review of the denial. I may charge you a fee for providing copies. I will advise you of the cost of those copies at the time I arrange for you to pick them up or have them delivered to you. I will compute these fees based on state guidelines. You may also have to pay for the cost of postage or shipping, depending on how you ask that we get these copies to you. I may not be able to deny your request for copies based on your inability to pay for them.

Amendment: You may ask me to amend your medical information if you believe that it is incorrect or incomplete. Your request must be in writing and must include a reason to support the amendment. Your request may be denied if I believe that the information is complete and accurate, if the information is not part of the medical information that you would be permitted to inspect or copy, or if I did not create the information. If I deny your request to amend your medical information, you may write a brief statement about the accuracy of my records and ask that I make it part of your medical record. This statement will be disclosed whenever the pertinent part of your medical record is disclosed.

Accounting of Disclosures: You may request a List of non-routine disclosures that I have made of your medical information over the previous six (6) years. Any accounting you receive will not include disclosures we make for your treatment, payment, or for our normal business operations as noted in the section on permitted uses and disclosures, for those disclosures you authorize in writing, and for certain other disclosures for which I am not required to account pursuant to applicable Law. You may not request an accounting for dates of service prior to April 14, 2003. Upon your request, I will provide one (1) free accounting each 12 months, but I may charge for additional accountings within the same period.

Breach Notification: I must notify you if I have reason to believe your unsecured medical information has been compromised due to unauthorized acquisition, access, use or disclosure.

Copy of This Notice: You are entitled to receive a paper copy of our Notice of Privacy Practices.

File a Complaint: If you believe that I have violated your privacy rights, you may file a complaint directly with me. To file a complaint with me, please submit your complaint in writing at 1169 Pittsford-Victor Road, #145, Pittsford, NY 14534. All complaints must be submitted in writing. You may also file a complaint with the Secretary of the Department of Health and Human Services. I will not retaliate against you for filing a complaint.