ASSOCIATED CLINICAL PSYCHOLOGISTS, LTD.
1580 N Northwest Highway, Suite 311D, Park Ridge, Illinois 60068 (847)824-1235

WELCOME TO OUR PRACTICE

As the president and owner of this practice, I want you to know I am extraordinarily happy you chose us to help you in your time of need. Quite frankly, it is an honor.

You see, the counseling profession has undergone immense changes from what it was just a few short years ago. In theory and technique, we are way ahead, but not all of the changes have been good. With the coming of managed care, it feels as if a lot of the caring has gone out of the profession, as it has in many professions. Our staff has made a vow to ourselves that we aren't going to let that happen to this practice. We became counselors and therapists because we cared, and we don't want to lose that perspective.

Here is what this means for you. If you have an emergency, we are always available. Just call (847) 824-1235 anytime and someone will get back to you quickly, because an emergency is an emergency. If you work or your children go to school, we have late hours during the week and daytime hours on Saturday, in addition to our regular weekday hours.

You can also be assured that if you refer a friend or loved one to us, we are going to treat them with the same conviction and energy we use when helping you.

It means that if you have any problems or concerns at all, we will work with you in any way we can because that is what caring means.

Again, just let me say how glad I am and how appreciative the whole staff is that you have chosen ACP Consultants. It is an honor.

Sincerely,

Alan R. Graham, Ph.D.

ASSOCIATED CLINICAL PSYCHOLOGISTS, LTD.

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Mutual Expectations

INTRODUCTION

Because you have requested or been referred for professional services to a member of our clinical staff, we want to be clear about the expectations we have of each other, and your rights as a patient.

Associated Clinical Psychologists, Ltd., (ACP) provides professional and confidential treatment designed to meet the needs of children, adolescents, adults, older adults, and the disabled. Crisis Intervention is available 24 hours a day, 7 days a week through our phone service. Our services include individual, couple, group, and family psychotherapy. Patients with the need for extensive community supports, in-patient care, or hospitalization can also be accommodated.

PSYCHOLOGICAL SERVICES

By the end of the initial evaluation, your therapist will be able to offer you some initial impressions of what the work will include and the initial treatment plan, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with your therapist. Therapy involves a significant commitment of time, money and energy, so you should be very careful and serious about your commitment. If you have questions about any procedures, they should be discussed with your therapist whenever they arise.

ACP is not affiliated with any other listed individual or organization sharing space in this office.

ASSOCIATED CLINICAL PSYCHOLOGISTS' EXPECTATIONS

TREATMENT CONTRACT

You will be asked to sign and return a treatment contract summarizing the points of this document.

WAITING ROOM

Parents who bring their children are expected to provide appropriate supervision at all times. Children are not to be left alone in the waiting room. Please keep the area safe for all by returning toys to the shelves after use.

Please remember that while you are waiting, others are in session with the therapists. Please keep noise to a minimum.

For everyone’s comfort, all areas of the office are non-smoking. Please do not bring food or drinks to the office with you.

APPOINTMENTS

Office hours are by appointment only, Monday through Saturday. The therapist you see will set his or her own appointment times. Sessions are normally forty five (45) to fifty (50) minutes long. It may be appropriate to utilize another therapist in the practice for evaluation, specialized treatment, or when your therapist is not available.

CANCELLATION

If you schedule and then must cancel an appointment, twenty-four (24) hours notice is required. You will be charged the full fee for late cancellations or for a missed appointment. Since insurance companies will not pay for missed sessions, you will be responsible for these charges.

FEES

Our fees are within the usual and customary range for this community. We require payment at the time of service. By agreeing to participate in treatment provided by our clinical staff, you agree to pay for these services according to the fee schedule given to you, or the co-payment amount indicated by your insurance company. We reserve the right to terminate the doctor-patient relationship for non-payment. We will arrange an extended payment plan if the need for such a service can be substantiated.

INSURANCE

Any payments received from third parties will be credited to your account, however, you are primarily responsible for the payment of the monthly statements. Use of insurance is accommodated. To facilitate receipt of mental health benefits, support staff will work with you to assist in filing claims. At first contact we will discuss your insurance and ask you to bring in your insurance cards. Late-cancel and failed appointment charges are not subject to third part payments and will not be listed in the monthly insurance statement. These charges must be met by the patient on an out-of-pocket basis.

WHAT YOU SHOULD KNOW ABOUT MANAGED CARE

The escalation of the cost of health care has resulted in an increasing level of complexity about insurance benefits, which sometimes makes it difficult to determine exactly how much mental health coverage is available. “Managed Care Plans” such as HMO’s and PPO’s often require advanced authorization before they will provide reimbursement for these services. These plans are often oriented towards a short term treatment approach designed to resolve specific problems that are interfering with one’s usual level of functioning. It may be necessary to seek additional approval after a certain number of sessions. While a great deal can be accomplished in short term therapy, many clients feel that more services are necessary after insurance benefits expire or payments are no longer authorized.

You should also be aware that most insurance agreements require you to authorize ACP to provide a clinical diagnosis, and sometimes additional clinical information such as a treatment plan or summary, or, in rare cases, the entire record. This information will become a part of the insurance company files, and, in all probability, some of it will be computerized. All insurance companies claim to keep such information

confidential, but once it is in their hands, ACP has no control over what they do with it. In some cases, they may share information with a national medical information data bank. At your request, ACP will provide you with a copy of any report submitted.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the available benefits, and what will happen if the insurance benefits end before you feel ready to end the sessions. It is important to remember that you have the right to pay directly for these services and avoid these complexities.

RETURNED CHECKS

A service charge will be applied to the account for checks returned by your bank for any reason.

If there are two or more checks returned by your bank, we will no longer accept a check for payment. You will be asked to pay by cash or credit/debit card only.

CONFIDENTIALITY

Confidentiality is a necessary condition for a successful working relationship and is protected, with few exceptions, by law. Reports are never sent anywhere and information is not shared with anyone outside of ACP unless you give written consent. ACP can not be responsible for what may happen to confidential information once it leaves our office. If you are under eighteen (18) years of age, your parents or legal guardians have a right to receive general information on the progress of your treatment, especially if the information concerns your health and safety. Our therapists consult with each other and with our Clinical Director for your benefit. Internal practice discussions are all bound by confidentiality.

Federal regulations do not protect information about a crime committed by a patient or information about a person who might be a danger to him or herself or to another person. Information about suspected child or elder abuse or neglect is also not protected by confidentiality by way of legal regulations.

REFERRALS AND TESTING

A therapist may determine that a referral needs to be made for you to see a Psychiatrist (M.D.) to be evaluated for possible medication or to see a psychologist for testing. You will be involved in such decisions and your therapist and staff will facilitate this referral.

TERMINATION

The therapist and the patient together will set goals and review progress. Should you decide to stop therapy, you should discuss your decision with the therapist.

PATIENTS' EXPECTATIONS, RIGHTS AND RESPONSIBILITIES

Access to treatment will not be denied on the basis of race, gender,
religion, ethnicity or any handicapping condition.

INFORMATION

You have the right to be informed about our practice expectations as listed above and any changes thereto. You also have the right to understand, participate in planning, and agree with the treatment you receive, as well as any changes in the treatment plan. You have the right to refuse any treatment and be informed of the consequences of such a refusal. You have the right to permit your family or guardian to exercise your rights if you have been judged incompetent.

COURTESY

You have the right to be treated in an ethical, professional and respectful manner and we expect courteous treatment of our staff.

ACCESS TO YOUR THERAPIST

You and your therapist will decide on how often you should have sessions. You have the right to contact your therapist through our twenty-four (24) answering service with the understanding that **phone conversations lasting more than ten (10) minutes may be subject to billing**. You have the right to cancel appointments up to twenty-four (24) hours prior to your appointment and to reschedule as the therapist is available.

CONFIDENTIALITY

You have the right to have your treatment be completely confidential, with few exceptions under Illinois law. No information is released (see above for exceptions) without your written consent. Children age twelve (12) and older have the right to decide whether to give written consent for release of information. If you have any questions about confidentiality, please discuss them with your therapist.

COMPLAINTS

You have the right to be told how to register a complaint, and the procedure for investigating the complaint, should a problem arise. You have the right to register a complaint without discrimination or fear of reprisal for doing so. A copy of our appeal policy will be provided upon request.

PAYMENT

Ultimately, payment for every service is your responsibility.

ASSOCIATED CLINICAL PSYCHOLOGISTS, LTD.
1580 N NORTHWEST HIGHWAY, SUITE 311D PARK RIDGE, ILLINOIS 60068
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INFORMED CONSENT FOR TREATMENT

PATIENT NAME:_____

You have requested professional services from a member of our clinical staff and have received a copy of the Mutual Expectations. This letter sets forth the agreement concerning our understanding of such services. This agreement shall become effective upon our receipt of a counter signed copy of this letter. Your signature also serves as an acknowledgment that you have received the HIPAA Notice of Privacy Practices.

1. You understand that these services involve evaluation, therapy, or nutrition counseling, and that whatever services are provided will be by mutual agreement between you and the clinician.

2. If you participate in whatever services are recommended by your clinician, you agree to pay for these professional services according to the fee schedule you have received.

3. We will charge you on the basis of time expended, and we reserve the right to terminate the relationship for non-payment. Any payments received from third parties(ie: insurance) will be credited to your account, however, you are primarily responsible for payment of any outstanding balances.

4. You will be charged the **FULL FEE** for late cancellations (less than 24 hours) and missed appointments.

5. The fee for written reports will be $50 for each 15 minutes. A $20 service charge will be applied for checks returned by your bank for any reason. If two or more checks are returned, we will no longer accept checks and you will be asked to pay cash.

6. Our Practice Manager will arrange a payment plan, at your request, if the need for such arrangements can be established.

7. We reserve the right to designate the performance of professional services to our associate(s) if it becomes necessary in order to provide appropriate care. This would include, but is not limited to, coverage for therapist vacation or illness, testing, etc.

8. In the event it becomes necessary to use the courts to collect any unpaid balance, you agree to pay reasonable attorney's fees and any and all court costs which may be incurred by us in connection herewith.

Please counter-sign this agreement so we may have a mutual memorandum of our understanding. You may request a copy of this document for your records.

Sincerely,

ACP CONSULTANTS

FEE SCHEDULE AND MUTUAL EXPECTATION GIVEN, UNDERSTOOD AND APPROVED:

_____DATE_____/_____/_____

WITNESSED:_____ R-4/03

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CANCELLATION/MISSED APPOINTMENT POLICY

Cancellation of an Appointment
In order to be respectful of the needs of other patients, please be courteous and call ACP Consultants promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another patient the possibility to have access to timely care.

Late Cancellations
Late cancellations will be considered as a "no-show." ********Please see No-Show Policy below

No-Show Policy
A "no-show" is someone who misses an appointment without cancelling it with sufficient notice. "No-shows" inconvenience those individuals who need access to care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in your record as a "no-show." This "no-show" appointment will result in a fee of $175.00, equivalent to a regular psychotherapy session. These charges are not covered by your insurance.

Patient
Name:_____Date:_____

Patient
Signature:_____

Witness:_____

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FEE SCHEDULE

The charges for direct and indirect services are as follows:

OUTPATIENT

Comprehensive Diagnostic Interview	$250
Intermediate Diagnostic Interview	$225 per 45 minutes
Individual Psychotherapy	$175 per 45 minutes
Family Therapy	$175 per 45 minutes
Brief Interview	$125
Adult Group Therapy	$50 per session
Psychological Testing	Per Test
Written Reports	$50 per 15 minutes

INPATIENT

Hospital Admission Interview	Based on Time
Diagnostic Interview	$250 per 45 minutes
Individual Psychotherapy	$225 per 45 minutes
Family Therapy	$225 per 45 minutes
Brief Interview	$125
Psychological Testing	Per Test
Written Reports	$50 per 15 minutes

Lengthy phone calls will be charged at the brief interview rate. Charges for extended sessions will be pro-rated based on time. Necessary professional consultations will be charged if they exceed 15 minutes either in direct or indirect time. Please keep in mind that some insurance carriers will not pay for these types of services.

Sincerely,

ACP CONSULTANTS

ACP Consultants
1580 N Northwest Highway, Suite 311D Park Ridge, Illinois 60068
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Child Information Form

Date: _____
Patient's Name:_____
Patient's Address:_____
Patient's City:_____State:_____Zip:_____
Home Phone #:_____Date of Birth:___/___/___ Age:_____
Name of School:_____Grade:_____Male:_____Female:_____
Referred by:_____Phone #:_____
Name of Physician:_____Physician Phone #:_____
Medication Allergies:_____
Emergency Contact:_____
Relationship:_____Contact Phone:_____

Brothers and Sisters:
Name:_____Age:_____School Name:_____
Name:_____Age:_____School Name:_____
Name:_____Age:_____School Name:_____

PERSON FILLING OUT THIS FORM:
Name:_____
Billing Address:_____
Billing City:_____State:_____Zip:_____
Billing Phone#: _____Cell Phone#:_____
E-Mail Address:_____
Employer:_____
Work Address:_____
Work City:_____State:_____Zip:_____
Work Phone #:_____Driver's License #:_____

Next-of-Kin Information
Mother's Name:_____Occupation:_____
Home Phone#:_____Work Phone#:_____
Cell Phone #:_____Age:_____
Address (if different than patient)_____
City_____State:___Zip:_____SS#:_____
Father's Name:_____Occupation:_____
Home Phone#:_____Work Phone#:_____
Cell Phone #:_____Age:_____
Address (if different than patient)_____
City_____State:___Zip:_____SS#:_____

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IMPORTANT NOTICE FOR PATIENTS USING INSURANCE

When authorization for the initial session(s) is required by your insurance plan, this is the responsibility of the patient/insured. If you do not have proof of initial authorization at the first session, we require payment in full. All future authorizations will be handled by our staff.

Most insurance plans include a co-payment. Payment of the co-payment is required at each session. We do not send statements for co-payments. If you are unsure of the co-payment amount, please contact your insurance carrier.

Our staff is happy to file claims for patients with more than one insurance plan if the information is provided at the initial session. The patient/insured will be required to coordinate the benefits among the plans. If you need assistance, please feel free to contact our practice manager at extension 2.

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(847)824-1235

FEIN: 36-3419655 NPI: 1578665147 STATE LIC #: 060-00431

INSURANCE INFORMATION FORM

Please fill in the portion below OR attach a copy of your insurance card. We will copy your card in the box below. Please be sure to SIGN BELOW.

PATIENT NAME_____

INSURANCE COMPANY_____
INSURANCE ADDRESS_____
INSURANCE COMPANY PHONE #_____/_____ - _____
GROUP #_____POLICY #_____
INSURED'S SOCIAL SECURITY # _____ - _____ - _____
NAME OF INSURED_____
DATE OF BIRTH OF INSURED_____
EMPLOYER OF INSURED_____
EMPLOYER'S ADDRESS_____

ATTACH INSURANCE CARD

HERE

DOES YOUR INSURANCE REQUIRE AUTHORIZATION FOR THIS VISIT? Y or N (circle one)

IF YES, WHAT IS THE AUTHORIZATION NUMBER?

_____

I/WE AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM. I/WE ALSO AUTHORIZE THE PAYMENT OF BENEFITS DIRECTLY TO THE ABOVE NAMED SUPPLIER WHO ACCEPTS ASSIGNMENT. IT IS UNDERSTOOD THAT THE UNDERSIGNED HAS THE RESPONSIBILITY FOR PAYMENT OF SERVICES. ASSIGNMENT OF BENEFITS DOES NOT RELEASE THE UNDERSIGNED FROM RESPONSIBILITY FOR PAYMENT.

SIGNED_____DATE_____/_____/_____
(INSURED PERSON AND/OR PATIENT)
ADDRESS_____
TELEPHONE_____/_____ - _____
SIGNED_____DATE_____/_____/_____
(PATIENT - IF AGE 12 OR OLDER)

ACP Consultants

Secure Credit Card Information Form

Please provide your credit card information to cover your copayments and coinsurance costs

We understand that some individuals may prefer not to submit credit card information electronically. If you feel more comfortable, you are welcome to call our office at (847)8241235 directly to provide the details verbally. Our team is here to accommodate your preferences and ensure a secure and seamless experience.

MasterCard/Visa/Discover/Amex Card Number

_____

Expiration Date _____/_____/_____ 3-Digit Number on Back_____

Your Printed Name On Card_____

Your Address_____

City, State, Zip Code_____

Your Signature _____Date_____

1580 N Northwest Highway, Suite 311D, Park Ridge, Illinois 60068; (847)824-1235 (office); (847)824-2386 (fax)

ASSOCIATED CLINICAL PSYCHOLOGISTS, LTD.
1580 N NORTHWEST HIGHWAY, SUITE 311D PARK RIDGE, ILLINOIS 60068
(847)824-1235

NOTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION TO PRIMARY CARE PHYSICIAN

NAME OF PATIENT:_____DATE OF BIRTH:_____/_____/_____AGE:_____

We are required by law to inform you that you may elect to allow Associated Clinical Psychologists to notify and confer with your primary care physician, if you have one, about receiving mental health services. Unless you waive such notification, we are required to notify your primary physician that you are receiving mental health services.

Please indicate your choice by **initialing** the appropriate line:

_____ I do not have a primary care physician and do not wish to confer with one. I therefore waive notification of a primary care physician that I am receiving mental health services.

_____ I do not want to notify my primary care physician that I am receiving mental health services.

_____ I agree to allow Associated Clinical Psychologists to notify and confer with my primary care physician regarding the mental health services I am receiving, and have completed the form below authorizing such notification.

I/WE HEREBY AUTHORIZE: **ASSOCIATED CLINICAL PSYCHOLOGISTS, Ltd.**

TO RELEASE TO/REQUEST FROM (PRIMARY CARE PHYSICIAN): _____

PHONE: _____

THE FOLLOWING INFORMATION FOR THE PURPOSES OF TREATMENT PLANNING

_____HEALTH/MEDICAL RECORDS	_____NEUROPSYCHOLOGICAL EVALUATIONS
_____SOCIAL HISTORY	_____PSYCHOLOGICAL ASSESSMENTS AND DIAGNOSIS
_____PSYCHIATRIC EVALUATIONS	_____PRIOR TREATMENT RECORDS AND REPORTS

_____OTHER (PLEASE SPECIFY)_____

I/WE UNDERSTAND THAT I/WE HAVE THE RIGHT TO INSPECT AND COPY THE INFORMATION TO BE DISCLOSED. I/WE UNDERSTAND THAT I/WE MAY REFUSE TO CONSENT TO DISCLOSURE PRIOR TO THE INFORMATION BEING SENT. I/WE UNDERSTAND THAT INFORMATION MAY BE TRANSMITTED VIA TELEPHONE, MAIL OR FACSIMILE.

I/WE HAVE READ THE ABOVE AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS CONCERNING THIS CONSENT, **INCLUDING THE CONSEQUENCES, IF ANY,** OF REFUSAL TO CONSENT.

_____ _____/_____/_____
PATIENT SIGNATURE DATE
AGE 12 AND OLDER MUST SIGN

_____ _____
PARENT/GUARDIAN WITNESS

THIS CONSENT IS VALID UNTIL _____/_____/_____ SIX MONTHS FROM THE DATE IT IS SIGNED.

Notice of ACP Consultants' (ACP) Policies and Practices to Protect the Privacy of Your Health Information

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

1. Uses and Disclosures for Treatment, Payment, and Health Care Operations

ACP may *use* or *disclose* your *protected health information (PHI),* for *treatment, payment, and health care operations* purposes with your *written authorization. To* help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*
  - *Treatment* is when ACP provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when ACP consults with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when ACP obtains reimbursement for your healthcare. Examples of payment are when ACP discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. - *Health - Care Operations* are activities that relate to the performance and operation of the practice of ACP. Examples of matters such as audits and administrative services, and case management health care operations are quality assessment and improvement activities, business-related and care coordination.
- *"Use"* applies only to activities within ACP [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- *'`Disclosure"* applies to activities outside of ACP [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.
- *"Authorization"* is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

ACP may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when ACP is asked for information for purposes outside of treatment, payment, or health care operations, ACP will obtain an authorization from you before releasing this information.

ACP will also need to obtain an authorization before releasing your Psychotherapy Notes. *"Psychotherapy Notes"* are notes your ACP provider may have made about conversations during a private, group, joint, or family counseling session, which your ACP provider has kept separate from the rest of your record. These notes are given a greater degree of' protection than PHI.

You may revoke all such authorizations (or PHI or Psychotherapy Notes) at any time, provided each

revocation is in writing. You may not revoke an authorization to the extent that (1) ACP has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

ACP will also obtain an authorization from you before using or disclosing:
· PHI in a way that is not described in this Notice.

III. Uses and Disclosures without Authorization

ACP may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* -If your ACP provider has reasonable cause to believe a child known to me in my professional capacity may be an abused child or a neglected child, he/she must report this belief to the appropriate authorities.

- *Adult and Domestic Abuse* -If your ACP provider has reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, he/she must report this belief to the appropriate authorities.

- *Health Oversight Activities* - ACP may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.

- *Judicial and Administrative Proceedings* - If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and ACP must not release such information without a court order. ACP can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.

- *Serious Threat to Health or Safety* -If you communicate to your ACP provider a specific threat of imminent harm against another individual or if your ACP provider believes that there is clear, imminent risk of physical or mental injury being inflicted against another individual, your ACP provider may make disclosures that he/she believes are necessary to protect that individual from harm. If your ACP provider believes that you present an imminent, serious risk of physical or mental injury or death to yourself; your ACP provider may make disclosures he/she considers necessary to protect you from harm.

- *Worker's Compensation* - ACP may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

- When the use and disclosure without your consent or authorization is allowed under other sections

of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, ACP is not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing an ACP provider. On your request, ACP will send your bills to another address.)

- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI in ACP's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record and Psychotherapy Notes. On your request, your ACP provider will discuss with you the details of the request for access process.

- *Right to Amend*- You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. ACP may deny your request. On your request, your ACP provider will discuss with you the details of the amendment process.

- *Right to an Accounting*- You generally have the right to receive an accounting of disclosures of PHI. On your request, your ACP provider will discuss with you the details of the accounting process.
- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

- *Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket.* You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
- *Right to Be Notified if There is a Breach of Your Unsecured PHI.* You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Psychologist's Duties:

- ACP is required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

- ACP reserves the right to change the privacy policies and practices described in this notice. Unless ACP notifies you of such changes, however, we required to abide by the terms currently in effect.

- If ACP revises its policies and procedures, ACP will provide you notice at your next scheduled appointment, or if a request for information comes to ACP before your next appointment, ACP will notify you by phone of our revised policies and procedures prior to release of any information.

V. **Questions and Complaints,**

If you have questions about this notice, disagree with a decision your ACP provider makes about access to your records, or have other concerns about your privacy rights, you may contact Alan R. Graham. PhD at 847-824-1235

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Alan R. Graham, PhD, ACP Consultants, 2604 Dempster Street, Suite 510, Park Ridge, Illinois 60068

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice went into effect on April 14, 2003 and was updated on August 5,

2023

ACP Consultants
1580 N Northwest Highway, Suite 311D
Park Ridge, Illinois 60068
(847) 824-1235