Cecilia M. Duarte Ph.D.
Licensed Clinical Psychologist

1130 Ten Rod Rd. E101
North Kingstown, RI 02852
Phone: 401-294-6900 ext. 3
Fax: 401-294-6690
Website: cduarteandassociates.com

Acknowledgment of Required Intake Forms

I acknowledge that I have been given copies of:

- the *Psychotherapist-Patient Services Agreement* and
- the *HIPAA Privacy Notice*

to review and discuss with my therapist.

Please review and sign the *Psychotherapist-Patient Services Agreement*.

Please also review the *HIPAA Privacy Notice*. The *HIPAA Privacy Notice* does not require your signature.

Please let me know as soon as possible if you have any questions or concerns about doing this.

_____ _____
Signature of Patient (or Parent/ Legal Guardian) Date

_____
Relationship to Patient

INTAKE FORM Clinician's Name: **Cecilia M. Duarte Ph.D**. Date_____

PERSONAL INFORMATION:

Patient Name _____Date of Birth_____

Address_____

City/State/Zip_____

Phone Home (___)_____Cell (_____)_____Office (_____)_____

Who referred you to our office? _____

RESPONSIBLE PARTY: (fill in if under 18 or if someone other than patient is responsible for payment)

Name _____ **Date of birth** _____

Address_____

City/State/Zip_____

Home Phone (_____)_____Business Phone (_____)_____

FINANCIAL POLICY

Appointments cancelled with less than 24-hour notice will be charged **$75.00**.
I am responsible for the entire balance of services performed regardless of whether there is insurance coverage.
Secondary insurance will be billed as a courtesy.
I understand and agree to the above stated financial policy.

Signed _____Date_____

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Psychotherapy & Consultation

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INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risk of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the other person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g. phone number where you can be reached) to restart the session or reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video session will be reimbursed; if they are not reimbursed, you are responsible for full payment.

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- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Psychologist Name / Signature: _____

Patient Name: _____

Signature of Patient/Patient's Legal Representative: _____

Date: _____

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Psychotherapist-Patient Services Agreement

Welcome to Cecilia M. Duarte PHD, Inc. (the "Practice," "We," or "Our"). This Psychotherapist-Patient Services Agreement (the "Agreement") contains important information about the Practice's professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act ("HIPAA"), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information ("PHI") used for the purposes of treatment, payment, and health care operations. HIPAA requires that the Practice provide you with a Notice of Privacy Practices (the "Privacy Notice") for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is given with this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that the Practice obtain your signature acknowledging that the Practice has provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before your next session. We can discuss any questions you have about the procedures at that time with your therapist. When you sign this Agreement, it will represent a binding and valid agreement between you and the Practice.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient, and the particular problems you are experiencing. There are many different methods used to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things We talk about both during your sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, you will be offered some first impressions of what the work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with the Practice. Therapy can involve a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about the Practice's procedures, we should discuss them whenever they arise. If your doubts persist, We will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

An evaluation will typically be conducted that generally lasts between 2 to 4 sessions. Sessions usually last for 45 to 50 minutes, although they may be longer in some cases. Please understand that occasionally

an emergency may interfere with our ability to start promptly. If you arrive late, your session will not be extended and will end at the scheduled time. However, you will be charged for a full session even if you arrive late.

APPOINTMENT CANCELLATION POLICY

If it is ever necessary to cancel or reschedule an appointment, We ask that you contact the Practice as soon as possible by calling the office. If you give more than 24 hours notice, there will be no charge for the cancelled session. If you call to cancel an appointment with less than 24 hours notice, or do not show for a scheduled appointment, you will be charged the full fee for the appointment.

PROFESSIONAL FEES

You agree to pay for all services provided by the Practice. The current fees are as follows: (i) $350 for an initial child diagnostic interview, (ii) $300 for an initial adult diagnostic interview, (iii) $100 for a 30 minute session, (iv) $150 for a 45 minute session, (v) $175 for a 50 minute session, and (vi) $200 for a 60 minute session. You agree to pay the hourly rate of $200 for all other services provided by the Practice including but not limited to report writing, consulting with other professionals, preparation of records or treatment summaries, review of, and response to any form of communication including telephone calls, voice mail message, and electronical communication such as e-mail and text messaging, responding to requests from third parties related to workers compensation claims, family and medical leave time, temporary disability insurance, and disability insurance, and the time spent performing any other services you may request. The Practice bills in 15-minute increments for all time spent other than diagnostic interviews and sessions and will send a monthly invoice to you with an itemized statement of fees and costs. Payments are due upon receipt of the Practice's invoice. If you become involved in legal proceedings that require Our participation, you will be expected to pay for all time and expenses, including but not limited to time preparing and attending meetings, depositions, hearings, and transportation costs, even if We are subpoenaed by another party. You understand that the Practice can change its fees at any time by providing written notice to you.

CONTACTING ME

The most appropriate time to discuss any issues of concern is during our scheduled sessions. If you need to contact the therapist and/or Practice outside of your scheduled session, please call the office. You understand if you contact the therapist and/or Practice by any other means such as text or email that We have no obligation to respond to you. In the event of an emergency, you can contact your therapist and/or the Practice by calling the office. If there is no response at the office, please call the Practice's answering service at (401) 384-6339. Do not contact the Practice by any other means including but not limited to calling a cell phone, texting, or emailing. While We want to be able to respond to your emergency call when needed, please understand that We may not always be able to do so. In the event of a clinical emergency, if you are unable to reach the Practice immediately, you should contact your primary care physician (or child's pediatrician) and/or proceed to your nearest hospital emergency room.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of communications between the Practice and a psychotherapist. In most situations, We can only release information about your treatment to others outside of the Practice if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for the Practice to release information about your treatment as follows:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, We make every effort to avoid revealing the identity of Our patient. The other professionals are also legally bound to keep the information confidential. We generally will not tell you about these consultations unless We feel that it is important to Our work together. We will note all consultations in your Clinical Record (which is called "PHI" in Our Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Your Health Information).

- You should be aware that the Practice practices with other mental health professionals and employs administrative staff. In most cases, We need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the Practice without Our permission.

- We have a contract with a billing service. As required by HIPAA, We have a formal business associate contract with this business, in which it promises to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. We will ask for your permission before having the billing service contact you directly.

- If a patient threatens to harm himself/herself, We may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where the Practice is permitted or required to disclose information without either your consent or authorization including the following:

- The Practice is under a court order or subpoena and you fail to inform the Practice that you are opposing the subpoena within 5 days of the subpoena being served on the Practice.

- If a government agency is requesting the information for health oversight activities, the Practice may be required to provide it for them.

- If a patient files a complaint or lawsuit against the Practice or any of its therapists, the Practice in its discretion may disclose relevant information regarding that patient in order to defend the Practice and/or therapist.

- If a patient files a worker's compensation claim, information that is directly related to that claim must, upon appropriate request, be provided to the Workers' Compensation Commission.

There are some situations in which We are legally obligated to take actions which We believe are necessary to attempt to protect others from harm and the Practice may have to reveal information about a patient's treatment.

- If We have reason to know or suspect that a child has been abused or neglected, or has been a victim of sexual abuse, the law requires that the Practice file a report with the Department for Children, Youth and Families. Once such a report is filed, the Practice may be required to provide additional information.

- If We believe that a patient presents a risk to the patient or another person , We may be required to take protective actions including warning the potential victim(s), contacting the police, or seeking hospitalization of the patient.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, according to the rules of HIPAA, We keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records received from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone. In addition, We also keep a set of Psychotherapy Notes. These Notes are for Our own use and are designed to assist in providing you with the best treatment. While the content of Psychotherapy Notes vary from client to client, they can include notes regarding the contents of our conversations, analysis of those conversations, and how they impact your therapy. They also can contain particularly sensitive information that you may reveal that is not required to be included in your Clinical Record. You may examine and/or receive a copy of both sets of records, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in Our presence or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, We are allowed to charge a fee for copying records. The exceptions to this policy are contained in the Privacy Notice.

PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that We amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others other than court order or subpoena; requesting an accounting of most disclosures of Protected Health Information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about Our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Privacy Notice, and Our privacy policies and procedures. We are happy to discuss any of these rights and/or issues with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes Our policy to request an agreement from parents that they consent in writing to give up their access to their child's records. If they agree, during treatment, We will typically provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. We may also provide parents with a summary of their child's treatment when it is complete. Most other communication will require the child's authorization, unless We feel that the child is in danger or is a danger to someone else, in which

case, We will notify the parents of Our concern. Before giving parents information, We will discuss the matter with the child, if possible, and do the best to handle any objections he/she may have.

BILLING AND PAYMENTS

You agree to pay the fee for each session at the time it is held. In certain situations (e.g., psychological testing, extensive evaluations, or document preparation), I may ask for a deposit toward the expected charges prior to beginning the services.

If you have an outstanding balance of $300 or more, you will not be permitted to book any additional appointments and/or attend any sessions until the balance has been paid in full. If you have a balance outstanding for more than 30 days and arrangements for payment have not been agreed upon, We have the option of using legal means to secure the payment. This may involve hiring a collection agency or filing a lawsuit which will require disclosure of otherwise confidential information. In most situations, the only information We release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. Interest will also accrue on any balance more than 90 days past due at the rate of 1½% per month. In the event the Practice deems it necessary to engage an attorney to collect overdue amounts, you agree that the Practice will be entitled to recover its reasonable attorneys' fees from you.

INSURANCE REIMBURSEMENT

In order for the Practice to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it may provide some coverage for mental health treatment. The Practice will fill out forms and provide you with whatever assistance We can in helping you receive the benefits to which you are entitled; however, *you* (not your insurance company) are ultimately responsible for full payment of my fees.

It is very important that you find out exactly what mental health services are covered by your specific insurance policy. You are always responsible for all charges for services that are not paid by your insurance plan. If you should change insurance plans, if the terms of your existing insurance plan should change, or if you lose your insurance, you must notify the Practice as soon as possible.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. Most insurance plans do not provide coverage for the full range of services psychotherapists can provide to help people. While much can be accomplished within the limits imposed by most health insurance plans and managed care organizations, some people feel that they need or would like services beyond the coverage provided by their insurance. If this is the case, we can discuss these issues and related costs as circumstances warrant.

You should also be aware that your contract with your health insurance company requires that the Practice provide it with information relevant to the services that We provide to you. We are required to provide a clinical diagnosis. Sometimes We are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, We will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, We have no control over what they do with it

once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report We submit, if you request it. By signing this Agreement, you agree that the Practice can provide requested information to your insurance carrier.

Once We have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay directly for services yourself to avoid the problems described above.

MISCELLANEOUS

The Practice may from time to time recommend third party services such as other mental health professionals. The Practice makes no representations, expressed or implied, and no warranty or guaranty regarding any third party services recommended by the Practice. Nothing in this Agreement and nothing in the Practice's statements to you will be construed as a promise or guaranty concerning the outcome of your psychotherapy treatment. The Practice disclaims and makes no such promises or guarantees. To the extent you have a session via telephone, you agree not to record the session without the Practice's prior written consent which may be withheld in its sole discretion. This Agreement supersedes all prior agreements, whether written or oral, and sets forth the entire understanding and agreement with respect to the services provided to you by the Practice. There are no agreements or representations between you and the Practice unless specifically set forth in this Agreement. The failure of the Practice to exercise any of its rights or remedies as related to any covenant, obligation, or breach hereunder shall not be deemed to be a waiver of its ability or right to so exercise at a later time, or at any other time. No consent to or waiver of any breach, whether express or implied, shall be deemed to be a consent to or waiver of any other breach. No consent to or waiver of any provision of this Agreement, or to any breach, shall be effective unless in writing and signed by the Practice. No portion of this Agreement should be construed against any drafting party. You understand that this Agreement and the relationship between you and the Practice may be immediately terminated at any time without prior notice by the Practice providing written notice to you. The termination will become effective immediately when it is sent by the Practice regardless of whether you receive the termination notice. This Agreement is being delivered and is intended to be performed in the State of Rhode Island and shall be construed and enforced in accordance with the laws of that state without reference to the rules of conflicts of laws thereof.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA PRIVACY NOTICE DESCRIBED ABOVE.

_____ _____

Patient's Name Date

_____

Patient's Signature (or Parent/ Legal Guardian)

C. Duarte & Associates
1130 Ten Rod Rd. Suite 101
North Kingstown, RI 02852

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1. I am aware that if I cancel an appointment with less than 24 hours, I will be charged **$75.00**.

   Signature: _____

2. Credit Card Authorization I, the undersigned, authorize Psychotherapy Practices of North Kingstown, LLC. (PP of NK) to charge my credit card for psychological services. I also authorize PP of NK to charge my credit card **$75.00** if I (or the party for whom I am financially responsible) fail to show for a scheduled appointment, or do not notify your clinician at least 24 business hours in advance for a cancelled appointment.

3. I authorize charges to my credit card for the full amount due on outstanding account balances. I understand that PP of NK will be required to disclose information about my attendance and/or cancellation to my credit card company should a dispute arise. This form will be securely stored in a clinical file and, upon request, may be updated at any time. Card Type:

Visa/ MasterCard Card #:
_____

Expiration Date: _____ Verification/Security Code: _____

Name (as printed on card): _____

Billing Address: _____
(Street; City, State & Zip)

Signature: _____
(Patient or financially responsible party)

Date: _____

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HIPAA Privacy Notice

Notice of Psychologists' 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.

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

I may *use* or *disclose* your *Protected Health Information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. 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 I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychotherapist.
    - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose 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 my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "*Use*" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*Authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse:** If I have reasonable cause to know or suspect that any child has been abused or neglected, as defined below, or is a victim of sexual abuse by another child, I must, within 24 hours, transfer that information to the Rhode Island Department of Child, Youth and Families, or its agent.

  Child abuse and/or neglect is defined as a child whose physical or mental health or welfare is harmed, or threatened with harm when his or her parent or other person responsible for his or her welfare:

  - Inflicts, or allows to be inflicted physical or mental injury;
  - Creates or allows to be created a substantial risk of physical or mental injury;
  - Commits or allows to be committed an act of sexual abuse, sexual assault against, or exploitation of the child;
  - Fails to supply the child with adequate food, clothing, shelter, or medical care;
  - Fails to provide the child with a minimum degree of care or proper supervision or guardianship because of his/her unwillingness or inability to do so; and abandons or deserts the child.

- **Health Oversight:** If a complaint is filed against me with the Rhode Island Board of Psychology, the Administrator of Professional Regulation (of the Division of Health) has the authority to subpoena confidential mental health information from me relevant to that complaint.

- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I provided to you and the records thereof, such information is privileged under state law, and I will not release this information without: 1) written authorization by you or your legal representative; or 2) a subpoena of which you have received official notification and you have failed to inform me that you are opposing the subpoena; or 3) 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 will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** I may release your confidential health care information to appropriate law enforcement personnel, or to a person, if I believe that person or their family to be in danger from you.

- **Workers' Compensation**: If you file a worker's compensation claim, I must release your relevant mental health care information for the proceedings.

There may be additional disclosures of PHI that I am required or permitted by law to make without your consent or authorization; however, the disclosures listed above are the most common.

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 about you. However, I am 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 me. Upon your request, I 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 my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request 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. I may deny your request. On your request, I 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 regarding you. On your request, I 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.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will inform you either in person or by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, believe that your privacy rights have been violated and wish to file a complaint, or have other concerns about your privacy rights, you may discuss these with me at 1130 Ten Rod Road, North Kingstown RI 02852 , (401) 921-5400.

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

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

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

This notice will go into effect on September 5, 2006.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. At such time I will notify you of this change either in person or by mail. The current version of this document will always be available to you at my office.