KELLIN
(336) 355-6206 | www.kellinconnects.com
2110 Golden Gate Drive, Suite B, Greensboro, NC 27405

Welcome to Kellin, PLLC

Kellin, PLLC ("Agency") is a private behavioral health counseling and consulting agency. Our mission is to empower others to live meaningful lives filled with hope, healing, and happiness. Our vision is to cultivate healthy individuals, families, communities, and organizations that can thrive despite adversity to become their best selves. We believe that **connection** is an essential ingredient to finding hope, healing, and happiness. Authentic connections among individuals, families and communities have the potential of helping us through some of our most challenging times. Sometimes these connections are with others, and sometimes, these connections are with ourselves. Let's get started!

Please review these agreements carefully, as they set forth the understanding between you ("Client") and the Kellin, PLLC regarding the services you have requested and we will provide for you. If you have any questions, concerns or issues about the content of this Agreement please contact us for clarification before signing it.

Client Information

First Name: _____ **Middle:** _____ **Last:** _____

Date of Birth (MM/DD/YYYY): ___/___/_____ **Gender:** _____ **Race:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Emergency Contact Name: _____ **Emergency Contact Ph. Number** _____ **Relationship to Client** _____

Parent or Guardian Name(s) (if different from client):

First Name: _____ **Last Name:** _____ **Relation:** _____

First Name: _____ **Last Name:** _____ **Relation:** _____

In the unlikely event of an emergency with you in our building and/or in session, we will call 911 and request an ambulance. We will also call the emergency contact person that you listed above. At the arrival of the ambulance, we will give them the following information:

Hospital Preference: _____

Current Primary Care Physician: _____ **Phone:** _____

Allergies / Special Health Conditions:

Current Medications:

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INFORMED CONSENT FOR SERVICES

THIS AGREEMENT made this _____ day of_____ ("Effective Date") by and between the Agency and the Client listed above on the terms and conditions set out below:

1. **Term of Agreement**. The term of this agreement will start on the Effective Date, and will continue on an as-needed basis until the Agreement is terminated by either party, as provided hereunder.
2. **Services Requested**. We will provide assessment and treatment services agreed upon as set out in the Treatment Plan. The preferred day, time and duration of services will be mutually agreed upon by you and/or your representative and the agency.
3. **Termination**. Either "Client" or "Agency" may terminate this agreement at any time upon written notice to the other party. If either party terminates this Agreement, all fees due at time of termination will be due and payable by you immediately. We will refund any prepaid fees.
4. **Governing Law.** The laws of the State of North Carolina shall govern this agreement.
5. **Agency's Responsibilities**. The Agency responsibilities are outlined on the enclosed "*Rights and Responsibilities"* form
6. **Client's Responsibilities.** Your responsibilities are outlined on the enclosed *"Rights and Responsibilities"* form.
7. **Severe/Bad Weather.** In severe weather, we may determine it is not safe for our Clinicians to travel and provide services at our office that day and may have to cancel that day's service. When this occurs we will notify you and reschedule.
8. **Confidentiality.** There are some situations where disclose of information is required without either your consent or Authorization, including a court order, a government agency requesting the information for health oversight activities, if a client files a complaint or lawsuit against us for self-defense, and in some situations, worker's compensation claims. In addition, mandatory reporting laws require us to disclose information if we have cause to suspect that a child has been abused or neglected, or if we have cause to suspect that a disabled adult has had a physical injury or injuries inflicted upon such disabled adult, other than by accidental means, or has been neglected or exploited. Finally, if we determine that a client presents a serious danger to the client (yourself) or another, we may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client.
9. **Billing and Payments.** You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If you have insurance, it is very important that you find out exactly what mental health services your insurance policy covers. You are responsible for any fees that your insurance does not cover, your co-payment and any deductible at the time of service. By signing this Agreement, you agree that we can provide requested information to your insurance carrier or health plan.
10. **General Information.** You will be provided with a list of contact names and numbers in the event you have any questions or concerns or should an emergency arise.

Signature(s) Required

My signature and /or your representative's signature below indicates that I am consenting to treatment services at Kellin, PLLC. I have received and understand and consent to the contents of the Agency Policies, including Consent for Services, the Notice of Privacy Practices (HIPAA), the Electronic Communications Agreement, and the Clients Rights and Responsibilities. I understand the contents of these documents and have had the opportunity to ask any questions

_____ _____
Signature of Client Date

_____ _____
Signature of Parent or Legal Guardian (if client under 18-years-old) Date

SUPPLEMENTAL CONSENT TO TREAT A MINOR (IF CLIENT IS UNDER THE AGE OF 18)

Welcome to Kellin, PLLC! We are excited to begin connecting with you to help you reach your goals. During our first session, we will ask to speak with you and learn more about your strengths and hopes for our time together. This is your space and time so please feel free to bring anything with you that you think you and your counselor might find helpful.

Parents/guardians, please note that in general, it is important to maintain the confidentiality of the client as the client works toward their treatment goals. During treatment, we will provide only general information about the progress of the child's treatment. However, parents/guardians, if the counselor is made aware that anyone is in danger of harming themselves or someone else, you will be notified immediately.

In addition, parents should be aware that, under N.C. General Statute 90-21.5, minors may consent for their own treatment for certain services, including medical health services for the prevention, diagnosis, and treatment of venereal and other communicable diseases, pregnancy, abuse of controlled substances, and emotional disturbance. In those situations, without the minor's permission, a provider of mental health services cannot notify a parent that the minor is receiving services.

Parents/guardians are required to stay on the premises during each session, although you may or may not participate in each session depending on the client's individualized treatment goals.

Signature(s) Required

By signing below, you give permission for Kellin, PLLC to see your minor child for counseling and agree to the stipulations outlined above and to the Consents & Agreements.

_____	_____
Child's Name (Print)	Date
_____	_____
Parent/Guardian's Name (Print)	Date
_____	_____
Parent/Guardian's Signature	Date

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FINANCIAL AGREEMENT

You are responsible for all co-pays, deductibles, co-insurance, non-covered services and balances. Payment is due at the time services are rendered unless other arrangements are approved in advance. I hereby agree to reimburse the Agency for the costs of pursuing collection, including attorney fees. It is my responsibility to inform the Agency of any changes that might affect the billing or charges to my account. In cases of divorce or separation, the parent authorizing treatment for the child will be the parent responsible for charges. If the divorce decree requires the other parent to pay for all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent. If you fail to uphold your payment arrangements, the Agency can pursue collection of any unpaid balance due.

Payments: Acceptable forms of payment include American Express, Visa, Mastercard, check, cash and money order. Payments can also be made online at www.kellinconnects.com. If mailing, please remit payment to: Kellin, PLLC, 2110 Golden Gate Drive, Suite B, Greensboro, NC 27405. If writing a check, please make checks payable to: **Kellin, PLLC** Any returned checks shall incur a $25.00 fee in addition to any outstanding balance for services rendered, due immediately. Additionally, checks will no longer be accepted as a future form of payment.

Service Fees: Our usual and customary fee for an intake session (60 minutes) is $250.00 and follow up sessions (60 minutes) is $175.00. If you intend to utilize insurance benefits, your actual cost out of pocket may be substantially less, depending on your coverage.

Appointments: We realize that, on occasion, you may not be able to make a scheduled appointment. Please remember that your appointment is reserved especially for you. Therefore, you will be charged the full fee for missed appointments that were not cancelled at least 24-hours in advance. By signing this agreement, you understand that you will be charged the full fee for missed or cancelled appointments if you provide less than a 24-hour notice.

Medical Records: Should you request medical records, fees will be incurred consistent with North Carolina *Statute 90-411* at the following rates: Pages 1 - 25 : $0.75 per page; Pages 26 - 100 : $0.50 per page; Pages 100+ : $0.25 per page; Minimum charge : $10.00

Legal Court Proceedings: If a Therapist is required to appear in a legal proceeding for a current or former client there will be a $200.00 minimum scheduling fee which is payable at the time the subpoena is delivered, and a $250 per hour court or legal proceedings fee.

Other Paperwork: We reserve the right to charge a fee for the compilation of other types of paperwork that is requested by the client (i.e., work-related forms, school forms, etc). This fee will be assessed and agreed upon prior to the completion of the forms.

Insurance Information: In compliance with health insurance regulations, Kellin, PLLC requires that all co-payments are collected at the time of service. We do not have the option to waive co-payments, deductibles or co-insurance amounts as that would be a violation of the contract we have in place with our insurance companies. You must provide your insurance card at your initial visit so that we may keep a copy on file. In addition, should your insurance change, we must be alerted to avoid denied claims. Should a claim be denied, you will be responsible to pay the amount denied by your carrier. It is your responsibility to pay any charges not eligible or covered by your insurance plan. If you discontinue care for any reason, all balances will become immediately due and payable in full by you, regardless of any claim submitted. Because we are a fee for service provider, we typically do not send billing statements, but they are available upon request.

Insurance Policy Owner Name:			**Insurance Policy Owner DOB:**			**Relation to Client:**
Primary Insurance Information			**Secondary Insurance Information (if applicable)**			**Private Pay**
Insurance Co.:			Insurance Co:			$ for Intake
Co-Pay: $	*Deductible $	Co-Insurance: %	Co-Pay: $	*Deductible $	Co-Insurance: %	$ for Follow-Up
**A deductible requires a credit card on file*						
☐ Visa ☐ Mastercard ☐ Discover			Card Number		Exp. Date	CVV Code
**I hereby give consent to charge the credit card indicated for any outstanding balance as a result of deductibles, co-payments, co-insurance, or other amounts due according to this agreement and information provided by my insurance company.*			Card Holder Name			
			Signature			**Date**

Signature(s) Required

I understand all of the elements of the Financial Agreement outlined above. I authorize Kellin, PLLC to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Kellin, PLLC. I understand that I am responsible for payment of services rendered by Kellin, PLLC, regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify Kellin, PLLC immediately if there are changes to the client's health condition or health plan coverage.

_____ _____

Signature of Responsible Party / Insured Date

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CONSENT TO CONTACT AND ELECTRONIC TRANSMITTAL

We are sensitive to your privacy and the confidentiality of services. For rescheduling or appointment confirmation purposes, it may occasionally be necessary for our office to contact you.

Check each method of communication approved to send information.

O **Phone / Voicemail Communication at HOME/CELL** **Provide phone number: _____**	O **Phone / Voicemail Communication at WORK** **Provide phone number: _____**
O **Email Communication – Provide email address:** **Email: _____** **Email communication will mainly be used for appointment reminders and scheduling and should not be a method of trying to reach your therapist.*	O **Text Communication – Provide phone number:** **Provide phone number: _____** **Text communication will mainly be used for appointment reminders and should not be a method of trying to reach your therapist.*

I give my consent for Kellin, PLLC to send by electronic transmittal (fax or email) or communicate by cellular phone, with appropriate release of information, confidential information concerning my or my child's diagnosis, care, testing records, treatment plan and goals. I have the right to revoke this authorization at any time. Revocation is not effective in cases where the information has already been disclosed but will be effective moving forward.

I give my consent for Kellin, PLLC to use a web-based scheduling calendar. I understand that while the web-based scheduling calendar may not meet all of HIPAA's stringent requirements, it does use the secure https protocol in which the data between computers and the server is encrypted and that access to computers and the calendar are password protected.

I am fully aware that electronic transmittal, wireless telephone communication and web based systems are subject to difficulties and that Kellin, PLLC cannot and does not guarantee confidentiality of such technology.

I understand Kellin, PLLC will exercise all reasonable precautions and I will in no way hold the Agency liable for any difficulties resulting to me or any other family member from the communication of confidential information by means of cellular phone, fax, email or web-based scheduling systems. I have the right to refuse to sign this authorization and my treatment will not be conditioned on signing.

Signature(s) Required

I understand all of the elements of the Consent to Contact and Electronic Transmittal outlined above.

_____ _____

Signature of Responsible Party / Insured Date

Client Bill of Rights

Kellin, PLLC does not discriminate on the basis of religion, race, gender, marital status, age, sexual orientation, national origin, previous incarceration, disability or public assistance status. Every client has the right to:

1. be cared for by qualified, competent and trained clinician, and be treated with courtesy, dignity and respect;
2. be spoken to or communicated with in a manner or language they can understand;
3. receive privacy and confidentiality in regards to their health, social, and financial circumstances, in accordance with laws and Agency policies;
4. be informed of the laws, rules and policies affecting the operation of the Agency;
5. be informed of procedures for initiating complaints about the delivery of service, without fear of reprisal or retaliation;
6. be informed of the cost of services and procedures for notifying them of any increase in the cost of services;
7. participate in the development of a plan for their care;
8. be briefed on any procedure/treatment before it is carried out in order that they can give informed consent or refuse the service/treatment;
9. expect that the Agency will only release information about them if they have given authorization and/or if it is a requirement of law; or it is for treatment or payment purposes.
10. receive notice of any changes in their service, within an agreed upon amount of time, prior to the changes place;
11. receive services, including access to medical care, without regard to race, color, age, sex, sexual orientation, creed, religion, linguistics, disability and/or familial/cultural factors;
12. be free from any actions that would be deemed to be abusive. e.g. intimidation, physical/sexual/verbal/mental/emotional/material or financial abuse, etc.;
13. report instances of potential abuse, neglect, exploitation, involving any employee of the Agency.
14. be dealt with in a manner that recognizes their individuality and is sensitive to and responds to their needs and preferences;
15. be informed, within a reasonable amount of time, of the Agency's plans to terminate the care or service and/or their intention to transfer their care to another agency.

Client Responsibilities:

Clients are responsible for:

1. providing complete information about matters relating to their mental health and abilities when it could influence the care they are being given;
2. reporting any potential risks that might exist to the clinician such as the possibility that a client/family member might have a contagious illness or condition;
3. reporting unexpected changes in their condition;
4. requesting information about anything that they do not understand;
5. contacting the office with any concerns or problems regarding services;
6. following service plans and/or expressing any concerns they have about the *Service Plan*;
7. accepting the consequences, if the *Service Plan* is not followed;
8. following the terms and conditions of the *Service Agreement*;
9. notifying the Agency, in advance, of any changes to scheduled appointments;
10. being considerate of property/equipment belonging to the Agency and/or clinician;
11. notifying Agency of any changes being made to their contact information such as address or phone number;
12. advising Agency of any changes being made to their Health Care Professionals. e.g. Primary Physician, Psychiatrist, Occupational Therapist, Nurse, etc.
13. advising the Agency if they are not satisfied with the care or services being delivered;
14. assume financial responsibility for all materials, supplies and equipment required for their care;
15. giving reasonable notice, when possible, if service is going to be cancelled;
16. treating clinicians in a courteous and respectful manner, and,
17. ensuring that clinicians are free from any actions that could be deemed to be abusive such as intimidation, physical/ sexual/ verbal/ mental/ emotional/material/ financial abuse, etc.

Agency Responsibilities

The Kellin, PLLC shall be responsible for:

1. providing competent clinicians;
2. carrying liability and other insurances;
3. ensuring behavioral health service delivery standards are met;
4. ensuring federal, state, county & municipal legalities are researched and applied;
5. adhering to labor regulations;
6. conducting needs assessments, with client's/family's input;
7. developing service plans with client's/family's input;
8. being part of, or coordinating, a treatment team to provide for the client's needs, as indicated;
9. establishing goals with client/client's representative's input and striving to meet these goals;
10. maintaining the client's/family's confidentiality, privacy and dignity;
11. maintaining professionalism and a code of ethics;
12. avoiding inflicting its personal values and standards onto clients;
13. being alert for and reporting signs of abuse or neglect.

This *Rights and Responsibilities* form has been reviewed with, and a copy given to, the named client/client's representative.

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Notice of Privacy Practices (HIPAA)

HIPAA (Health Insurance Portability and Accountability Act) was enacted by the Federal Government in 1996. It serves a number of purposes: 1) It allows persons to qualify immediately for comparable health insurance coverage when they change employers; 2) It mandates the use of code set and format standards for the electronic exchange of healthcare data; 3) It requires the use of national identification systems for healthcare patients, providers, payers (or insurance plans), and employers (or sponsors); and 4) It mandates measures be taken to protect the security and privacy of personally identifiable healthcare information, and that patients have a right to access their healthcare information. The U.S. Department of Health and Human Services has the responsibility for oversight of these mandates.

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

OUR LEGAL DUTY:

The Law Requires Us to:

- Keep health information about you that can be identified with you (**P**rotected **H**ealth **I**nformation, or **PHI**), private.
- Make a copy of this Notice describing our legal duties, privacy practices, and your rights regarding your medical/health information available to you.
- Notify affected individuals following a breach of unsecured PHI.
- Follow the terms of this Notice of Privacy Practices that is now in effect.

We have the Right to:

- Change the terms of this Notice at any time, provided they are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical/mental health information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

- Before making an important change in our privacy practices, we will change this notice, post the revised notice in our office; and make copies of the revised notice available upon request.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION:

The following section describes different ways that we may disclose **p**rotected **h**ealth **i**nformation (**PHI**). Such information may include, but is not limited to: name of doctor providing services, summary of diagnosis, functional status, treatment plan, symptoms, prognosis, progress to date, frequency of treatment, session dates and duration, medications, and results of clinical tests. PHI disclosed in this category does **not** include psychotherapy notes. Psychotherapy notes are separate from other PHI and are discussed in a special section below. We will not disclose your PHI for any purpose not listed below, without your specific written authorization.

Consent for Disclosure of PHI for Treatment, Payment, Health Care Operations (TPO):

We may disclose PHI without your specific authorization for treatment, payment, and health care operations.

- **For Treatment:** We may disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. In addition, we may disclose PHI about you when referring you to another health care provider.
- **For Payment:** Generally, we may give your PHI to others, i.e. insurance company, billing agency, or collection agency, to bill and collect payment for the treatment and services provided to you. Before you receive scheduled services and during treatment, we may share information about these services with your health plan(s). Sharing information allows us to ask for coverage under your plan or policy and for approval of payment.
- **For Health Care Operations:** We may disclose PHI in performing business activities, which we call "health care operations". These "health care operations" allow us to improve the quality of care we provide and reduce health care costs. Examples include 1) cooperating with outside organizations that assess the quality of the care we provide, i.e. inspections or audits, 2) assisting various people who review our activities, i.e., accountants, lawyers, and others who assist us in complying with applicable laws, 3) conducting business management and general administrative activities related to our organization and the services it provides, and 4) complying with this Notice and with applicable laws.
- **For appointment reminders, etc.**: We may contact you to provide appointment reminders or other health-related information that may be of interest to you. If you do not want to consent to this specific use of your PHI, please contact our office.

While specific authorization is not required for these uses and disclosures, we ask that you sign a general consent form for the use and disclosure of PHI for such treatment, payment, operations use as described above. You have the right to refuse to sign such a consent form; however, we may refuse treatment if such consent is not signed.

We may disclose PHI (including psychotherapy notes) under other circumstances without your authorization:

By law, we may disclose PHI about you, including psychotherapy notes, in a number of circumstances in which you do not have to consent, give authorization, or otherwise have an opportunity to agree or object. Those circumstances include:

- When required by law. For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding.
- When the disclosure is necessary for public health activities. For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- When the disclosure relates to victims of abuse, neglect or domestic violence.
- For health oversight activities. For example, we may disclose PHI about you to a state or federal health oversight agency which is authorized by law to oversee our operations.
- For judicial and administrative proceedings. For example, we may disclose PHI about you in response to an order of a court or administrative tribunal or to defend ourselves against a lawsuit or legal proceedings brought against us by yourself.
- For law enforcement purposes. For example, we may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.
- Regarding a person who has been deceased for more than 50 years.
- When the disclosure is for organ donation purposes.
- For certain research purposes in an institutional setting with a Review Board.
- To avert a serious threat to health or safety. For example, we may disclose PHI about you to prevent or lessen a serious and eminent threat to the health or safety of yourself or others.

- For specialized government functions. For example, we may disclose PHI about you if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.
- For workers' compensation functions.

Disclosures of PHI without your written authorization, opportunity to agree or object: By law, we may disclose PHI about you, without written consent or authorization, if you are told in advance and are given the opportunity to agree, object or restrict, orally or in writing, the use or disclosure in the following situations: 1) Facility directories, 2) Emergency circumstances (incapacity/emergency), 3) Disaster relief efforts, 4) Family member, relative, friend, or other person identified by the yourself, 5) Family member or other person who was involved in an individual's care or payment for care prior to that individual's death.

Other disclosures of PHI require your written authorization: Under most circumstances, including uses for marketing purposes or sale of PHI, other than those listed above, we must obtain your written authorization before we disclose PHI about you. Specific authorization obtained will include: a description of information to be used/disclosed, the name or specific identification of person authorized to make the disclosure; the name or specific identification to whom the information is to be disclosed; the purpose of the disclosure; the expiration date or event of the disclosure; and the signature of the client authorizing disclosure along with the date of the authorization. If you sign a written authorization allowing us to disclose PHI about you in a specific situation, you can later cancel your authorization in writing. If you cancel your authorization in writing, we will not make further disclosures after we receive your cancellation, except for disclosures which were being processed before we received your cancellation.

Psychotherapy Notes: Specific written authorization will be obtained from the client for the release of psychotherapy notes except: 1) for treatment, 2) payment, 3) health care operations; 4) our own training programs), 5) to defend ourselves in a legal action, and 6) in special situations noted above. Psychotherapy notes are defined as notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private, group, joint, or family counseling session, and that are separated from the rest of the individual's medical record. Excluded from this definition of psychotherapy notes includes, but is not limited to: frequency, dates, and duration of treatment, summary of diagnosis, functional status, treatment plan, symptoms, prognosis, progress to date, results of clinical tests, and medication prescriptions and monitoring.

YOUR INDIVIDUAL RIGHTS:

1. You have the right to request that we restrict the use and disclosure of PHI about you. We are not required to agree to your requested restrictions unless the disclosure is for payment or health care operations and is not otherwise required by law, and the PHI pertains solely to a healthcare care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full. However, even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures described above. Such request for restriction must be submitted to our office in writing.
2. You have the right to request how and where we contact you about PHI. For example, you may request that we contact you at your work address or phone number or by e-mail. Your request must be submitted in writing to our office. We must accommodate reasonable requests, but, when appropriate, may condition that accommodation on your providing us with information regarding how payment, if any, will be handled and your specification of an alternative address or other method of contact.
3. You have the right to inspect and/or receive a copy of your PHI (excluding psychotherapy notes). Your request must be submitted in writing to our office. We may charge you related fees. Instead of providing you with a full copy of the PHI, we may give you a summary or explanation of the PHI about you, if you agree in advance to the form and cost of the summary or explanation. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. We will inform you of our decision to grant or deny access to your PHI within 30 days of receipt of the request.
4. You may request to inspect and/or receive a summary of your psychotherapy notes; however, your request may be denied. If your request is denied, we will respond to you in writing, stating why we will not grant your request. You do not have any rights for a review of our denial. We will inform you of our decision to grant or deny access to your psychotherapy notes within 30 days of receipt of the request.
5. You have the right to request that we make amendments to clinical, billing and other records used to make decisions about you. Your request must be in writing and must explain your reason(s) for the amendment. We will act upon your request within 60 days of receipt of the request. We may deny your request if: 1) the information was not created by us (unless you prove the creator of the information is no longer available to amend the record); 2) the information is not part of the records used to make decisions about you; 3) we believe the information is correct and complete; or 4) you would not have the right to see and copy the record as described in paragraph 3 above. We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including persons you name who have received PHI about you and who need the amended information.
6. You have the right to request in writing a written list of our disclosures of PHI about you other than for treatment, payment, and health care operations, disclosures to yourself, and disclosures for which you previously provided written authorization. You may ask for disclosures made up to six (6) years prior to your request (not including disclosures made prior to April 14, 2003). If you request a list of disclosures more than once in 12 months, we can charge you a reasonable fee.

You have the right to request a paper copy of this Notice at any time by contacting our office.

QUESTIONS AND COMPLAINTS:

You have the right to file a complaint with the Department of Health and Human Services, 200 Independence Ave., SW, Room 509F Washington DC 20201. Before filing a complaint, or for more information, please contact our Director, Dr. Kelly Graves at info@kellinconnects.com or 336-355-6206.