Parkdale Therapy Group, LLC
1000 Shelard Parkway, Suite 520
St. Louis Park, MN 55426-1053

952-224-0399 Fax 952-224-0396

CLIENT INFORMATION PACKET

This booklet will help acquaint you with my office procedures, as well as provide information about your rights and responsibility with regard to therapy. You will also find updated information about your rights pursuant to the Health Insurance Portability and Accountability Act (HIPAA). If you have any questions about this information, please discuss them with me at any time.

DIRECTIONS

From the North take 169 south to Shelard Pkwy/ Betty Crocker Drive. Take Shelard Parkway to 1000 Shelard Parkway. Turn right into the parking lot, and if you park on ground level, use the main entrance to the elevators up to the fifth floor. Turn right and continue down the hall to suite 520.

From the South take 169 north to Shelard Pkwy/ Betty Crocker Drive. Take Shelard Parkway to 1000 Shelard Parkway. Turn right into the parking lot, and if you park on ground level, use the main entrance to the elevators up to the fifth floor. Turn right and continue down the hall to suite 520.

From the East take 394 west to 169 North and then exit on Shelard Pkwy/ Betty Crocker Drive. Take Shelard Parkway to 1000 Shelard Parkway. Turn right into the parking lot, and if you park on ground level, use the main entrance to the elevators up to the fifth floor. Turn right and continue down the hall to suite 520.

From the West take 394 east to Hopkins Crossroads exit and turn left to cross over 394, then take the first right (East) on N. Wayzata Blvd (frontage road) approximately six blocks to the six-story blue glass building with FOCUS FINANCIAL in white letters. Turn into the ramp and park, then take the walkway to the second floor elevators up to the fifth floor. Turn right and continue down the hall to suite 520.

Upon entering, please have a seat in the waiting room and I will come out to greet you at your appointment time. Help yourself to tea or water. If you'd prefer coffee, just let me know and I will be happy to grab you a cup and provide sugar and cream.

PROFESSIONAL RELATIONSHIP

Professional consultation is not easily described in general statements. It varies depending on the personalities of the consultant and client, and the concerns you are experiencing. There are many different methods we may employ to attend to the concerns that you hope to address. Consultation is not like a medical doctor and calls for a very active role on your part. It might even include other important people in your life. Consultation can have additional benefit as you work on your goals and strategies at home that we've talked about during our meetings.

Consultation can have benefits and some risks. Since consultation may involve discussing challenging experiences of your life, you may experience sadness, guilt, anger, frustration, loneliness, etc. On the other hand, consultation may have many benefits. Successful consultation can lead to increased satisfaction in relationships, new possibilities for addressing specific concerns, and/or reductions in feelings of distress. But there are no guarantees of what you will experience.
Our first few sessions will focus on understanding your needs, goals, and presenting concerns. After these first few sessions, we will be able to discuss your first impressions of what our work could include and then co-create a potential plan to follow, if we decide to continue with consultation. It is important to evaluate this information along with your own

opinions of whether you feel comfortable working together. Since consultation involves a commitment of time, money, and energy, it is important to be selective about the consultant you select. If you have questions about my procedures, we can discuss these whenever they arise. While we co-create possible solutions, you maintain the right to implement them, or decide against implementing any or all of them.

MEETINGS & PROFESSIONAL FEES

I conduct an initial session of approximately 55 minutes at a cost of $180. Following the initial session is an evaluation period of 2 to 3 sessions, during which we can both decide if I am the best person to provide the services you need to meet your goals. The fee for these 55-minute sessions is $180. I usually suggest one 55-minute session per week at a time, although some sessions may be shorter or longer or be scheduled more or less frequently. We work together to determine how often and for what length of time we meet. Once an appointment hour is scheduled, you will be financially responsible if you were to cancel without for 24-hour notice, in which case a cancellation fee of $180.00 would be charged. If were unable to attend due to circumstances beyond your control, such as an unforeseen emergency, sudden illness, etc., the cancellation fee would be waived. *It is important to note that insurance companies do not provide reimbursement for cancelled sessions charges.* Periodically we are faced with the issue of raising our rates. While this is not an annual change, there have been times when the hourly rate has increased $10.00/hour. In the event of a change, we will post these changes in our individual offices at least 90 days in advance and make every effort to verbally apprise you of the changes.

ADDITIONAL PROFESSIONAL FEES

In addition to weekly appointments, I charge $180 per 55 minutes for other professional services you may need, though I will break down the hourly cost if I work for periods of less than 55 minutes. Other services may include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and time spent performing other services you may request. These services may not be covered by insurance.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all my professional time, including preparation and transportation costs, and **ANY** legal fees that I might incur, even if I am called to testify by another party. I charge $180 per hour for preparation and attendance at any legal proceeding, and in addition, mileage to and from any location.

CONTACTING ME

When in the office, I am often not immediately available by phone, as I am likely with a client. If I am unavailable, incoming calls will forward to a voicemail that I monitor frequently. I will make every effort to return your call within 24 hours, except for weekends and holidays. If it might be difficult to reach you, please leave times when you might be available by phone. Please use our voicemail for messages of a critical nature.

EMERGENCIES

If you are experiencing an immediate crisis and are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call, or contact the Crisis Connection at (612) 379-6363, the St. Paul Ramsey Crisis Intervention Center at (651) 266-7900, or your local emergency services at 911. If I will be unavailable for an extended time, I will provide you with the name of a

colleague to contact, if necessary. **Email is generally used to make or change appointments, or for general questions not requiring an immediate response.** Please use our voicemail for messages of a critical nature.

BILLING AND PAYMENTS

You will be expected to make co-pays or deductibles for each session *at the time of the appointment*, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

INSURANCE REIMBURSEMENT

Your health insurance company requires an assessment covering a broad range of topics, typically more than may be covered in our initial session, and we are required to provide your insurance provider with information relevant to therapeutic services, including a clinical diagnosis. I will make every effort to release only the minimum information necessary for the purpose requested by your insurance company to process your claim. Upon request, you may have a copy of any report I submit. This information will become part of the insurance company files, and while your insurance company may endeavor to keep this information confidential, we have no control over what happens to the information once it is submitted. Your private information might become part of a national medical information databank, and could be used in determining future insurability. To avoid the problems described above [unless prohibited by contract] you may opt to pay for these services yourself.

Most insurance companies require that we coordinate care with your Primary Care Physician, so it is important that we have your written consent to do so. If you have any questions or concerns regarding this, we can talk more about those before I coordinate care with your physician.

We process all insurance claims on your behalf. Please do not submit insurance claims unless we instruct you to do so, as this might reject our claim to your insurance provider.

CONCERNS

I urge you to discuss with me any questions or concerns you may have with the consultation you receive. If you are not satisfied with the results of that discussion, and additional measures are necessary, a formal concern or complaint may be made with Ms. Michelle A. Craveiro, MA, LMFT whose number is 952-224-0399 ext 102.

Insurance Registration Form

Today's Date_____

Client Name (Print)_____ **Date of Birth** _____
Last First Middle Initial

Street
Address_____City_____

State_____ Zip_____ Sex: F ○ M ○ O○ Age ____ Partner Status: Sgl____○ Mar____○ Div____○ Sep____○ Other ____○

Cell Phone
May I Leave A Message? **Yes**○ **No**○

Work Phone
May I Leave A Message? **Yes**○ **No**○

Other Phone
May I Leave A Message? **Yes**○**No**○

Confidential Email Address: _____ May we send unencrypted confidential email? **Yes**○ **No**○

Employer _____Occupation _____

Primary Care Physician: _____ Phone: _____ May I contact: **Yes**○ **No**○

Insurance ***Please note: *I am not a Medicare provider****

Primary Insurance Company_____ Phone ( ) _____

Claims Address_____City_____State_____Zip_____

Policy/ID # Group/Plan # _____
(This can be the Policy Holder's social security number)

Policy Holder Information: (if the client is not the employee/policy holder)

Name_____ Relationship _____
Last First Middle Initial

Address_____City_____State____Zip_____

Employer_____ Date of Birth _____

Diagnosis _____ Therapist _____
(Required for Billing Insurance – Therapist will fill in)

Secondary Insurance Company_____ Phone ( ) _____

Policy/ID #_____Group/Plan # _____
(This can be the Policy Holder's social security number)

Policy Holder Information: (if the client is not the employee/policy holder)

Name Relationship _____
Last First Middle Initial

Address_____City_____State____Zip_____

Employer_____ Date of Birth _____

Diagnosis _____ Therapist _____
(Required for Billing Insurance – Therapist will fill in)

Responsible Party (Where should the personal portion of the bill be sent, if not to the person named at the top of the page?)

Name _____ Relationship _____

Address_____Phone _____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider (therapist) listed on this form all insurance benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges not covered by insurance. I hereby authorize the healthcare provider (therapist) to release all information necessary to secure the payment of benefits and to mail billing statements. I authorize the use of this signature on all insurance submissions. I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider (therapist) listed on this form all insurance benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges not covered by insurance. I hereby authorize the healthcare provider (therapist) to release all information necessary to secure the payment of benefits and to mail billing statements. I authorize the use of this signature on all insurance submissions. *I understand John L Jankord is not a Medicare provider and cannot accept Medicare of any type for reimbursement of services.*

_____ _____ _____
Signature of Responsible Party Relationship (self, parent, etc) Date

Additional Resources

Some problems can isolate people from support or help. For this reason, I am a believer in coordinating with concerned others during our work together. By utilizing other supportive people, we are not forced to deal with these challenges(s) alone. When you think about supportive others or resources, who or what might you want to include? Examples include family, friends, medical professionals, social workers, teachers, coaches, people or activities which provided a positive influence, such as authors, hobbies, pets, books, movies, etc.

I am also interested in others who know about the concern(s) you are facing. I've found some people may have knowledge or experience that could be useful when we discuss the impact these problems and their potential solutions. Concerned others may know of ways you have stood up to these or other challenges in the past. Feel free to list these people, so that if we both decide it would be helpful to contact them, we will have their information. Please note I will obtain your written permission *before* consulting with any of these people.

Potential contact/resource _____ Relation to You?_____

Work Phone _____Cell/Other Phone _____ Email _____

Potential contact/resource _____ Relation to You?_____

Work Phone _____Cell/Other Phone _____ Email _____

Potential contact/resource _____ Relation to You?_____

Work Phone _____Cell/Other Phone _____ Email _____

Potential contact/resource _____ Relation to You?_____

Work Phone _____Cell/Other Phone _____ Email _____

Potential contact/resource _____ Relation to You?_____

Work Phone _____Cell/Other Phone _____ Email _____

Other Resources

Hobbies/Special Interests/Abilities

Emergency Contacts

My first priority is maintaining the safety and privacy of those with whom I consult. If there comes a time when I am concerned with your safety or the safety of others in your life, I may need to contact them. I ask you provide two names of people I could call if I am concerned about your safety. If you are the parent of a client I am seeing, there may be times when I am unable to contact you immediately and need someone else to verify your child's safety. Please list these individuals below.

Emergency Contact Name _____ Relation to You? _____

Work Phone _____ Cell/Other Phone _____ Email _____

Emergency Contact Name _____ Relation to You? _____

Work Phone _____ Cell/Other Phone _____ Email _____

Emergency Contact Name _____ Relation to You? _____

Work Phone _____ Cell/Other Phone _____ Email _____

CONFIDENTIALITY AGREEMENT

Information about clients and their families is confidential with exception to the following:

1) Written authorization by the client and/or family (valid authorization form).
2) Therapist's duty to warn another in the case of potential suicide, homicide or threat of imminent, serious harm to another individual.
3) Therapist's duty to report suspicion of abuse or neglect of children or vulnerable adults.
4) Therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, and amphetamine or their derivatives, THC, or excessive & habitual alcohol use. (253b.02; 2007).
5) Therapist's duty to report the misconduct of mental health or health care professionals.
6) Therapist's duty to provide a spouse or parent of a deceased client access to their child or spouse's records.
7) Therapist's duty to provide parents of minor children access to their child's records. Minor clients can request, in writing, that particular information not be disclosed to parents. Such a request should be discussed with the therapist.
8) Therapist's duty to release records if subpoenaed by the courts.
9) Therapist's obligations to contracts (e.g. to employer of client, to an insurance carrier or health plan.

Consent for Sharing of Information

The Parkdale Therapy Group, LLC consists of a clinical team including: John L Jankord, MA, LMFT, LADC, LPCC; Michelle Craviero, MA, LMFT; Jessie Brown, Psy D, LP; Heather Klein, Ph D, LP; Tyra Hughes, MA, LMFT; Randi Born, Psy D, LP, MA, LMFT; Annie Will, MA, LMFT; Jake Voelker MA, LMFT; Tiffany Leuthold, MS, LMFT; Michelle Hunt-Graham, MA, LMFT, CDWF; Aysem Senyurekli, PhD, LMFT; Libby Marx, MA, LMFT; Jessee Daley, MA, LPCC; Megan A. Jankord, MA; Kate Schmidt, MSW, LICSW.

The purpose of consulting with colleagues is to obtain additional insight, further therapeutic skills, and ensure the highest possible service to the people we serve. During collegial consultation we will make every effort to provide only those details necessary to gain adequate feedback.

My signature indicates I understand the above limits of confidentiality and the possible participation of interns.

_____ _____

Client Signature Date

_____ _____

Parent Signature For Minor Client Date

As a client, you have the right to know and inquire about the following:

1) The cost of counseling, time frame for payment, access to billing statements, billing procedure for missed appointments, and any issues related to insurance coverage.

2) When the therapist is available and where to call during off hours in case of emergency.

3) The manner in which the therapist conducts sessions concerning intake, treatment, and termination. Clients may take an active role in the process by asking questions about relevant therapy issues, specifying therapeutic goals, and renegotiating goals when necessary.

4) The nature and perspective of the therapist's work, including techniques used, and alternative methods of treatment.

5) The purpose and potential negative outcomes of treatment. Clients may refuse any treatment intervention or strategy.

6) The anticipated length and frequency of treatment and limitations that may arise due to difficulties in financing.

7) The liberty of clients to discuss any aspect of their therapy with others outside the therapy situation, including consultation with another therapist.

8) The status of the therapist, including the therapist's training, credentials, and years of experience.

9) The maintenance of records, including security and length of time they are kept, client's rights to access personal records, and release policies.

10) The right to request a referral and the right to require the current therapist to send a written report regarding services to the qualified referred therapist or organization upon the client's written authorization.

11) The procedure followed in the event of the therapist's death/illness.

- **I consent to this consultation, have read and understand my rights listed above, and have reviewed the Client Bill of Rights posted in our waiting room.**

_____ _____

Client Signature Date

_____ _____

Parent Signature For Minor Client Date

INDIVIDUAL CONFIDENTIAL QUESTIONNAIRE

Name: _____ **Date:** _____

How did you find out about my services? _____

May I acknowledge this referral? **Yes or No** Referent Phone/Email _____

What is the main concern(s) that brought you in for consultation at this time?

Who is the person and/or what is the challenge you are most concerned about and why?

LIST OF POTENTIAL CHALLENGES

Listed below are challenges you might be experiencing. Please rate each according to the degree **you** might be experiencing these. Circle the number to indicate the current intensity of the concern and explain briefly, what specifically make these a challenge at this time?

1. Depression? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

2. Thoughts/Actions of Self-Injury or Self-Harm? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

3. Worry/Anxiety? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

4. Family/Relational Conflict? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

5. Verbal Harm/Behavior/Threat? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

6. Sexual Harm/Behavior/Threat? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

7. Physical Harm/Behavior/Threat? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

8. Legal Challenge(s)? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

9. Financial Challenges? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

10. Internet Usage Challenges? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

11. Alcohol/Chemical Health Challenges? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

12. Gambling Challenges? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

13. Spiritual/Faith Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

14. Other Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

ASSESSMENT

Why do you think these challenges are present for you or are present in your relationship? How long have the challenges been present?

GOALS

What is the main goal(s) or hope you have for this initial consultation?

What are your ideas on how this goal – these goals might be accomplished?

What attempts have you made in the past toward these goals?

If the work together is helpful, what would be the short-term and longer-term outcome(s)?

As a result of you achieving these goals, what would be different in your life?

As a result of you achieving these goals, what might be different in the lives of others close to you?

Your signature below indicates that you have read the entire 10 pages of this document, that you understand the content, and agree to abide by its terms during our professional relationship. Your signature also indicates you have had an opportunity to ask questions about this material and how it applies to my situation, and that you have been offered the HIPPA MN Notice Form.

_____ _____

Client Signature Date

_____ _____

Parent Signature For Minor Client Date

Thank you for taking the time and care to provide this information.

MINNESOTA NOTICE FORM
Notice of Parkdale Therapy Group, LLC
Policies and Practices to Protect the Privacy of Client 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 a psychologist.
  - *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, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], 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, or 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 or 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 know or have reason to believe a child is being neglected or physically or sexually abused, or has been neglected or physically or sexually abused within the preceding three years, I must immediately report the information to the local welfare agency, police or sheriff's department.

- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult is being or has been maltreated, or if I have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, I must

- Immediately report the information to the appropriate agency in this county. I may also report the information to a law enforcement agency.

  "*Vulnerable adult*" means a person who, regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:
  (i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and
  (ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

- **Health Oversight Activities:** The Minnesota Board of Marriage and Family Therapy or Board of Behavioral Health may subpoena records from me if they are relevant to an investigation it is conducting.

- **Judicial and Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.

- **Serious Threat to Health or Safety**: If you communicate a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim, I must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. I must also do so if a member of your family or someone who knows you well has reason to believe you are capable of and will carry out the threat. I also may disclose information about you necessary to protect you from a threat to commit suicide.

- **Worker's Compensation**: If you file a worker's compensation claim, a release of information from me to your employer, insurer, the Department of Labor and Industry or you will not need your prior approval.

IV. Client's Rights and Clinician's Duties

Client's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information. 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. On 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 (and psychotherapy notes) in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial 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 for which you have neither provided consent nor authorization (as described in Section III of this Notice). 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.

Clinician'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 send you a copy by mail or give you a copy in session.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact **Ms. Michelle A. Craveiro, MA @ 952-224-0399 ext 102.**

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to:

Parkdale Therapy Group, LLC
1000 Shelard Parkway, Suite 520
St. Louis Park, MN 55426-1053

952-224-0399 Fax 952-224-0396

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. 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 became effective 4/14/03

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or in session.

Your signature below indicates you have read this notice form and have been offered a copy of the HIPPA Notice Form described above and had the opportunity to clarify any questions.

_____ _____

Client Signature **Date**

_____ _____

Parent Signature for Minor Client **Date**