PETER A. POWERS, PH. D.
511 East 12th Avenue
Eugene, OR 97401

CLIENT RIGHTS AND RESPONSIBILITIES-EVALUATION (CHILD/ADOLESCENT)

Assessment and Treatment Planning:

To provide you with the best care possible, it is important that I have a clear understanding of what brings you for evaluation. To assist me in this process, I will ask you to complete several forms about your health habits and family history. I will also ask you to describe the concerns that led to your seeking evaluation and administer psychological tests and questionnaires to supplement the information we discuss. Once all tests are administered, rating forms received back, and background information from previous evaluations and treatment are made available a report will be written summarizing the findings. Following this, you may be offered a feedback session to review the findings and discuss recommendations. It is critical that you actively participate in the evaluation process and candidly discuss your concerns. If at any time you feel misunderstood or feel the evaluation process is misguided, please bring this to my attention. Open communication and feedback needs to go on throughout the evaluation.

Risks and Benefits of Evaluation:

It is important for you to know that there are risks involved in any evaluation process, though every effort will be made to minimize these. For example, some people experience an increase in stress, particularly when discussing difficult historical information. Other risks may occur as well, depending on your unique situation (for example, if you involved in any legal matters, including custody disputes; are applying for life insurance for your child/adolescent; or they later seek to join the armed services or become a public safety official, disclose of this evaluation may be required). Please ask me about what risks you can expect and I will discuss others as I identify them. Not all clients are prepared for the evaluation process I use, nor am I able to evaluate all problems confronting my clients. As a result, if I determine that I cannot adequately evaluate you, or that treatment is needed in order for a valid evaluation to be conducted, I will inform you at the earliest opportunity and assist you to find more appropriate services. This could include referral to another mental health provider on an outpatient basis, or it could include referral to an inpatient psychiatric or chemical dependency program. Other referrals may also be appropriate. If at any time you have doubts about the appropriateness or effectiveness of the evaluation process with me, please discuss these doubts with me as soon as possible.

Rights to Privacy and Exceptions to Privacy:

The work that we do here is **CONFIDENTIAL**. The things that you choose to discuss with me are strictly private and protected by Oregon State laws. Except under unusual circumstances, discussed below, I will not share anything we talk about with others unless I have your written permission to do so. In evaluation children and adolescents it is often necessary for me to at least obtain some information with others, such as school or work personnel, or other family members. I routinely request permission to provide limited information to other current treating professionals, in order to insure coordinated care. In each case I will explain the need to share information and discuss the specific information to be shared. If that is acceptable, I will ask for your permission in writing by asking you to complete an "Authorization Form". Similarly, I will not seek or receive information from others who know you without first receiving permission from a legal guardian. I may consult informally with another provider of similar services, unless you specifically request that does not occur, in order to ensure the quality of the evaluation. Most often that is Erik Sorensen, Ph.D. If there is specific information you believe would be helpful for me to know about, particularly previous mental health treatment, please bring this to my attention as soon as possible.

It is very important for you to know that some things, by law, cannot be kept private. Here are the exceptions to your rights to privacy:

1) If I am subpoenaed or court ordered to testify in court, I may have to give information about you without your permission. If I am subpoenaed or receive a court order I will make an effort to contact you. If you oppose the release of information, a court may nevertheless order me to disclose information;
2) If I learn that harm has been done to a child, elderly person, or disabled person, I will make a report to authorities. Although Oregon law exempts psychologists from reporting child abuse (including physical, sexual and emotional abuse) and neglect, my experience is that such reporting is a necessary and helpful step in treatment AND it is my policy to do so;
3) If I learn of a client's specific intent to bring harm to himself, herself, or to another person, or to commit an act of violence, it is my responsibility to protect you and others. Under these circumstances I reserve the right to inform other family members, intended victims or authorities as appropriate;
4) A non-custodial parent who wants to learn about their child's treatment may have the right to review their child's treatment record and to discuss their child's evaluation with me.

Legal Proceedings/Court Involvement:

If you are involved or anticipate being involved in legal or court proceedings, please notify me as soon as possible. In the event you are requesting or have been asked to obtain a psychological evaluation, it is important for you to know the difference between a general evaluation and a forensic evaluation. Please recognize that a general psychological evaluation done to clarify diagnosis, develop treatment recommendations, or assist in determining eligibility for some service or program is NOT a substitute for an evaluation used in court or other forensic setting. If you need that type of evaluation I will be happy to assist you to find a provider offering that service. It is also important for you to know that I will not be a willingly participate as a party to any legal proceedings against current or former clients or their parents or family members. My goal is to help children and adolescents improve their functioning at home and school, not to address legal issues that require an adversarial approach**. Clients (or in the case of minors, their legal representatives) presenting for evaluation agree to not involve me in legal/court proceedings or attempt to obtain records of the evaluation for any legal/court proceeding, including those involving resolution of custody or visitation conflicts. This prevents misuse of a non-forensic evaluation for legal objectives. Clients (or in the case of minors, their legal representatives) also agree not to allow their attorney's or others they employ to obtain evaluation records for use in any legal proceeding. Should a legal issue arise that results in this evaluator being deposed or called as a witness by any party the financially responsible party identified on my forms is fully liable for all preparation, waiting, consultation, and testimony time at my usual hourly rate, as well as any incidental expenses such as transportation and lodging costs.**

Appointments/Cancellations/Payment/Billing:

Evaluations are scheduled by appointment and usually last 3 to 5 hours, sometimes over several days. If you are unable to keep a scheduled evaluation, please call me as far in advance as possible. Please read and sign the attached Registration Form. Insurance companies cannot be billed for late cancellations (less than 3 business days) or no-shows and **you may be charged a $500 late cancellation/no show fee. Late arrivals may also be charged a minimum of $140 or more to cover the cost of wasted time (see also below).** If Dr. Powers is delayed in starting your appointment you will only be charged for the time used. You are expected to pay any copayments and you may be asked to pay a deposit prior to your evaluation, especially if you have not met the deductible for your health insurance or you are paying for the evaluation privately. Insurance claim forms will be submitted by Dr. Powers but insurance companies and policies vary in the amount of coverage they provide. Insurance companies also may consider some services () outside of the benefit provided, thus electing not to pay for them (such as testing for learning disorders; telephone consultations involving discussion of your evaluation; consultations with other professionals and agencies, related travel, preparation of letters and reports, etc.). Regardless of the insurance company's handling of your claim, you are responsible for all fees. All services are charged at my hourly rate of $140 per hour. A $25 service charge will be added for any checks returned due to insufficient funds.

*Note that evaluation does not include emergency treatment services.

PETER A. POWERS, PH. D.
511 East 12th Avenue
Eugene, OR 97401
(541) 683-5567
(541) 344-7595 fax

CONSENT TO EVALUATE

I hereby consent to receive psychological services from Peter A. Powers, Ph. D.
In the event that the client is a minor, I affirm that I am their legal guardian, with the authority to authorize mental health services for them. I voluntarily agree to participate and cooperate in the process of completing a psychological evaluation. I understand that I have the right to refuse or revoke my consent for the evaluation at any time.

I understand that any information obtained or provided in the course of the evaluation may be included in the report Information may not be provided to other parties without the written consent of the client (or in the case of a minor the consent of either the custodial or non-custodial parent/guardian). However, I understand that some information, by law, cannot be kept private. The following conditions may result in the release of confidential information without my written consent. Information may be released to appropriate parties if not doing so will pose immediate and clear danger of harm to myself or others. Information may be released to appropriate parties if not doing so will further perpetuate the physical, mental, and/or sexual abuse of a child or elderly person. A court may rule to override privileged communication. There is no privileged communication if the client is involved in a legal proceeding that relies on the client's mental or emotional condition as an element of the client's claim or defense. There is no privileged communication if a judge orders and examination of the mental or emotional condition of the client. The information released will be directly relevant to the purpose of the court ordered evaluation unless the judge orders otherwise.

_____ _____

Client/Guardian Signature Date

PETER A. POWERS, PH. D.
511 East 12th Avenue
Eugene, OR 97401

EVALUATION REGISTRATION: (Please print) **Date**:

CLIENT INFORMATION

Patient Name:_____ Soc. Sec.#:_____-_____-_____ Sex:_____

Address:_____ City:_____ State:____ Zip:_____ Home Phone:_____

Age: _____ DOB:_____ Employed By:_____ Work Phone:_____

Who referred you?_____ Primary Physician:_____ Phone:_____

Other Counselors/therapists?_____ Phone:_____

INSURANCE

Person responsible for account:_____ Soc. Sec. #:_____-_____-_____ Sex:_____

Relationship to Client:_____ DOB:_____ Home Phone:_____ Bus Phone _____

Address (if different from client's):_____ Employed By:_____

Insurance Co._____ Address:_____ Phone:_____

Contract #:_____ Group #:_____ Subscriber #:_____ Plan Effective Date:_____

Managed Care Co./Authorizing Agent:_____ Phone:_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Peter A. Powers all insurance benefits, if any, otherwise payable to me for services rendered. Dr. Powers agrees to contact the insurance company prior to my first visit in an effort to clarify the benefit available to my family, and to provide me with that information on or before our first scheduled appointment. I understand that the insurance company makes no guarantee that all claims will be paid according to the information they provide, and that I am financially responsible for all charges that are denied by the insurance company, as well as for any copayment and deductible. Dr. Powers will file all claims with your insurance company, and in the event that a claim is denied, he will call them in an effort to address the reason for any denial of payment. I understand that it is my responsibility to follow up with my insurance company if that effort is unsuccessful, and that I will be billed directly for all charges once the insurance company has denied the claim. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship to Client Date

PETER A. POWERS, PH. D., LLC
511 East 12th Avenue
Eugene, OR 97401
(541) 683-5567
(541) 344-7595 fax

Client Responsibility for Full Payment of Services Not Covered by Insurance

Client Name: _____ Date:_____

Your insurance company has required that their members be fully informed in writing when psychological services will not be covered by insurance. It is important for you to understand when you will only be paying a small portion of a charge, with the remainder being billed to insurance, and when you will receive the full cost of a service. Unfortunately, it is seldom possible to fully clarify when insurance will and will not pay for services. Plans change, sometimes frequently, and insurance companies assert that any explanation of benefits provided before a service is provided is not a guarantee that they will pay as expressed.

By signing this form, you are affirming that you are aware that there are times when your insurance will not pay the cost of a service, because they believe it is not a covered service. Furthermore, your signature indicates that you agree to pay the full cost of these services. Examples of noncovered services include consultation by telephone, collection of collateral information from other treatment providers, schools, etc., and consultation with attorneys, schools, employers, etc. Insurance companies may also deny payment for sessions conducted without the identified client present, visits lasting longer than a standard hour, or when more than one visit is scheduled within the same week. Your signature below indicates your awareness that these and other services may not be covered under your insurance, and your agreement to pay the full cost of these services should they be denied by your insurance company.

Please note that every reasonable effort will be made to identify noncovered services ahead of time, so that you can decide whether to receive them or to limit services provided to those covered by your insurance. Unfortunately, not guarantee can be made that noncovered services will be avoided, given the lack of clarity regarding these matters provided by insurance companies.

_____ _____
Signature Date

EVALUATION BACKGROUND INFORMATION-CHILD/ADOLESCENT

(To be completed by parent/adolescent)

Identifying Information

Client's Name (First,middle,last)_____Today's Date_____

Age:_____Birth Date: _____Referral Source (if any)_____

Address: _____City, State, Zip:_____

Home phone:_____ Permission to contact? (Y/N)_____

Cell phone:_____Permission to contact? (Y/N)_____

Parent/guardian names:_____

Gender: (F/M/Trans/Other):_____Preferred Pronouns_____

Others Living In Home (name, age, relationship to client):_____

_____

Important Others Living Outside Home_____

Parent Years of School/Current Occupations:_____

Emergency Contact/Relationship:_____Phone:_____

Referral Concerns/Symptoms

Describe the problems(s) that led to you bring your child/adolescent for evaluation? How long has these problems been present? What would you like to learn as a result of this evaluation? List any previous evaluations known:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Is your child/adolescent currently experiencing any of the following? (please circle YES or NO)

Sadness or depression	Yes	No	Fears/anxiety/panic	Yes	No
Feeling tearful	Yes	No	Phobias/fears	Yes	No

Self-esteem problems	Yes	No	Guilt or shame	Yes	No
Change in sleep patterns	Yes	No	Fatigue	Yes	No
Defiance/oppositionality	Yes	No	Mood swings	Yes	No
Change in eating patterns	Yes	No	Stealing at home/elsewhere	Yes	No
Self harm behaviors	Yes	No	Thoughts of suicide	Yes	No
Lack of motivation	Yes	No	Perfectionism	Yes	No
Worry a lot	Yes	No	Sexual concerns	Yes	No
Feelings of extreme happiness	Yes	No	Racing thoughts	Yes	No
Increased/chronic irritability	Yes	No	Angry outbursts	Yes	No
Relationship problems	Yes	No	School problems	Yes	No
Aggression	Yes	No	Running away	Yes	No
Thoughts of hurting someone	Yes	No	Impulsive behavior	Yes	No
Hyperactivity/increased activity	Yes	No	Obsession/compulsions	Yes	No
Concentration/attention problems	Yes	No	Memory problems	Yes	No
Toileting problems	Yes	No	Substance use	Yes	No

Major life losses/other symptoms-list):_____

Ever hospitalized for mental health reasons? Yes No If yes, when/why_____

_____

Threatened or attempted suicide? Yes No If yes, when/how_____

Have other family member(s) received psychiatric medication/hospitalized for mental health reason or threatened or attempted suicide? Yes No If yes, who/how_____

Is your child/adolescent currently prescribed medication(s)?: Yes No If yes please list:

Name of current medication Dosage (mg) How often taken Reason Prescribed by

_____

_____

_____

Current/past therapists (Names/dates):_____

Name/dosages/reasons for past medications (if any)_____

_____

Over the counter medications? (If yes list): _____

Medical History (circle if present)

How would you rate your child/adolescent's current physical health? Poor Fair OK Good Very Good

Any major injuries or accidents? Yes No ; If Yes list:_____ Head injuries? Yes No Helmet use? Yes No; Weapons in home? Yes No; If yes how secured?_____

Major illnesses? Yes No If yes, explain_____

Allergies? Yes No If yes, list:_____Chronic pain/discomfort? Yes No If yes, where?_____

Sleep habits: Poor Fair OK Good Very Good; Bedtime:_____Wake Time:_____#Times awake_____

Current eating habits: Poor Fair OK Good Very Good; In past year fluctuated +/- 10 lbs.? Yes No

Primary Care Physician: (name/contact info)_____

Seat belt used every time? Yes No; Helmet used when on bike? Yes No; Weapons in home? Yes No;

If yes what kind/how many/how are they secured?_____

Exercise/sports/physical activity (how often/what kind):_____

Substance Use History

Has your child/adolescent used or do they currently use anything listed below? If so, at what age did they start/stop using? If current what form, how often and how much do you think they use?

Tobacco/nicotine_____Cannabis_____

Alcohol_____

Amphetamines_____Cocaine_____

Opiods_____Hallucinogens_____

Other(s)_____ Daily screen use (approx. #hours)_____

Do they think use is a problem? Yes No; If yes, why?_____

Does you consider their use a problem? Yes No; If yes why_____

Prior substance use treatment/counseling for addictive/compulsive behavior? Yes No Court ordered?

Gambling problems or ever hidden loss of money from others? Yes No; Details:_____

List current mental health/substance use treatment, including support groups? _____

Significant family history of substance use whether treated or not_____

Family/Relationship History

Where was child/adolescent born?_____; Birth order:___of__children Number of brothers_____sisters___; any half/step/foster/adoptive?_____ Who raised your child so far?_____

What has it been like parenting your child/adolescent? (Cultural identification; family make up; quality of relationships):_____

_____

_____

_____

How often has the child/adolescent moved? If often, why?_____

Have they experienced neglect, trauma, or abuse? (Will aid understanding of effects on daily life):

_____

_____

Have they experienced or observed domestic violence? Yes No; If yes please describe:_____

How does your child/adolescent define themselves culturally and spiritually?_____

Who is in their support system?_____

What do they do for fun? With who?_____

Names/Ages of other children in or out of the home (please state if bio/step/foster/adoptive):

_____

What is your perception of your child/adolescent's current relationships? (family difficulties, communication patterns, difficulties with peers and teachers/other adults):

_____

_____

_____

What is going well in their daily life/relationships?_____

_____

Educational/Work History/Legal Information

School Attended:_____; Current Grade:_____; Ever held back? Yes No

Typical grades earned:_____Any learning disabilities/IEP/504 Plan?_____

School staff contact (if any identified-e.g. case manager, teacher):_____

Is behavior at school a current problem? Yes No; If yes, describe:_____

_____Number of suspensions/detentions in current/past years:_____

Has your child/adolescent ever worked for pay outside the home? Yes No; If yes, describe and state how many hours a week?_____

Please list any current or past legal issues (ex: MIP, traffic infractions shoplifting, child custody cases, etc.)_____

Additional Comments:_____

_____

_____

OREGON NOTICE FORM

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" (Protected Health Information) includes any individually identifiable health information received or created by my office or me.
"Health information" is information in any form that relates to any past, present, or future health of an individual.

- *"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 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 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. I may use or disclose confidential information (including but not limited to PHI) for purposes of treatment, payment, and healthcare operations when your written informed consent is obtained. I may use or disclose PHI for purposes outside of treatment, payment, and healthcare operations when your appropriate written 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.

I will also obtain an authorization from you before using or disclosing

- PHI in a way that is not described in this Notice.

III. Uses and Disclosures 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 believe that a child with whom I have had contact has been abused I may be required to report the abuse. Additionally, if I have reasonable cause to believe that an adult with whom I have had contact has abused a child, I may be required to report the abuse. In any child abuse investigation, I may be compelled to turn over PHI. Regardless of whether I am required to disclose PHI or to release documents, I also have an ethical obligation to prevent harm to my patients and others. I will use my professional judgment to determine whether it is appropriate to disclose PHI to prevent harm.If there is a child abuse investigation, I may be compelled to turn over your relevant records.

- **Mentally ill or Developmentally Disabled Adults**: If I have reasonable cause to believe that a mentally ill or developmentally disabled adult, who receives services from a community program or facility has been abused, I may be required to report the abuse. Additionally, if I have reasonable cause to believe that any person with whom I come into contact has abused a mentally ill or developmentally disabled adult, I may be required to report the abuse. Regardless of whether I am required to disclose PHI or to release documents, I also have an ethical obligation to prevent harm to my patients and others. I will use my professional judgment to determine whether it is appropriate to disclose PHI to prevent harm.

- **Other Abuse:** I may have an ethical obligation to disclose your PHI to prevent harm to you or others.

- **Health Oversight:** The Oregon State Board of Psychologist Examiners may subpoena relevant records from me should I be the subject of a complaint.

- **Judicial or Administrative Proceedings:** Your PHI may become subject to disclosure if any of the following occur:
  1. If you become involved in a lawsuit, and your mental or emotional condition is an element of your claim, or
  2. A court orders your PHI to be released, or orders your mental evaluation.

- **Serious Threat to Health or Safety:** I may disclose confidential information when I judge that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person. I must limit disclosure of the otherwise confidential information to only those persons and only that content which would be consistent with the standards of the profession in addressing such problems.

- **Worker's Compensation:** If you file a worker's compensation claim, this constitutes authorization for me to release your relevant mental health records to involved parties and officials. This would include a past history of complaints or treatment of a condition similar to that in the complaint.

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

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information 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 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.

- *Right to Restrict Disclosures When You Have Paid for Your Care Out-of Pocket*-You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

- *Right to Be Notified if There is a Breach of Unsecured PHI*-You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPPA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Psychologist's Duties:

- 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 during your course of treatment or evaluation, I will provide you with a revised Notice by posting a copy in my office.

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 request that I review my decision again. Please call my regular office number or speak to me in person about such a request. If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to me at my regular office address. 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 23, 2013

I will limit the uses or disclosures to the extent that such limitation does not affect my right to make a use or disclosure that is required by law or, when in good faith, to use or disclose to avert a serious threat to health or safety of a person or the public and such use or disclosure is made to a person or persons reasonably able to prevent or lessen the threat (including the target of the threat).

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. If changes are made I will provide you with a revised notice by posting a copy in my office.

PETER A. POWERS, PH. D., LLC
511 East 12th Street
Eugene, OR 97401
(541) 683-5567

ACKNOWLEDGMENT OF RECEIPT OF OREGON NOTICE FORM

I (client or client's representative)_____hereby acknowledge that I have received a copy of the Oregon Notice Form (Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information).

_____

Client/Client's Representative Signature Date