Thomas L. Murray, Jr., PhD, PLLC

Intake Form

Sex Therapy ● Couples Counseling ● Individual Counseling ● Transgender Mental Health Provider

Your answers below will provide preliminary information about you and enable us to prepare for your first meeting. If you have not sent the completed form to Dr. Murray by email (drtom@triadsexpert.com), please bring it with you to your first session.

What type of therapy/counseling are you pursing at this time?

Individual ☐ **Couples** ☐ **Group** ☐ **Coaching** ☐

Please share with us your reasons for seeking psychotherapy/counseling at this time: (check all that apply)				
☐ Depression	☐ Anxiety	☐ Relationship Issues	☐ Marital Issues	☐ Mood Disorders
☐ Sexual Issues	☐ Trauma	☐ Parenting/Children	☐ Grief/Loss	☐ Career/Work
☐ Addictions	☐ Sexual Identity	☐ Anger	☐ Substance Abuse	☐ Other
In your own words, briefly describe your reasons for seeking therapy/counseling:				

IF YOU ARE IN A RELATIONSHIP, PLEASE PROVIDE INFORMATION ABOUT YOUR PARTNER/SPOUSE ON THE SECOND PAGE OF THIS FORM

PLEASE PRINT CLEARLY **Today's Date:** _____

NAME: _____ **Birthdate:** _____

Last First Middle Initial Month/Day/Year

ADDRESS _____

Number and Street Name City State Zip Code

Primary Phone No: (_____)_____ **Cell** ☐ **Home** ☐ **Work** ☐ **Other** ☐

May we contact you & leave a message at this number? **Yes** ☐ **No** ☐

Emergency Phone No: (_____)_____

Contact Person Name: _____ **Relationship** _____

E-Mail Address: _____

May we contact you & send information to this email address? **Yes** ☐ **No** ☐`

Gender: **Male** ☐ **Female** ☐ **Transgender** ☐ **Gender Fluid** ☐ **Questioning** ☐

RACE		RELIGION		MARITAL STATUS	
☐ African American	☐ Hispanic	☐ Agnostic/None	☐ Jewish	☐ Single	☐ Married
☐ American Indian	☐ White	☐ Baptist	☐ Protestant	☐ Partnered	☐ Separated
☐ Asian	☐ Other	☐ Catholic	☐ Other	☐ Divorced	☐ Widowed

ROMANTIC / SEXUAL ORIENTATION				
☐ Heterosexual	☐ Mostly Gay/Mostly Lesbian	☐ Bi-Sexual	☐ Gay	☐ Unsure / Questioning

V1-2-15-16

Children			
Name	Age	Gender	Reside at Home (yes/no)

EMPLOYMENT STATUS: Employed ☐ Unemployed ☐ Retired ☐

If employed, please provide the name of your current employer: _____

What is/was your position title at your current or last job? _____

How long have/did you work for your current/last employer? _____

INFORMATION REGARDING SPOUSE/PARTNER (if attending couples counseling).

PLEASE PRINT CLEARLY

NAME: _____ Birthdate: _____

Last First Middle Initial Month/Day/Year

ADDRESS _____

Number and Street Name City State Zip Code

Primary Phone No: (_____)_____ Cell ☐ Home ☐ Work ☐ Other ☐

May we contact you & leave a message at this number? Yes ☐ No ☐

Emergency Phone No: (_____)_____

Contact Person Name: _____ Relationship _____

E-Mail Address: _____

May we contact you & send information to this email address? Yes ☐ No ☐

GENDER: Male ☐ Female ☐ Transgender ☐ Gender Fluid ☐ Questioning ☐

RACE		RELIGION		MARITAL STATUS	
☐ African American	☐ Hispanic	☐ Agnostic/None	☐ Jewish	☐ Single	☐ Married
☐ American Indian	☐ White	☐ Baptist	☐ Protestant	☐ Partnered	☐ Separated
☐ Asian	☐ Other	☐ Catholic	☐ Other	☐ Divorced	☐ Widowed

ROMANTIC / SEXUAL ORIENTATION				
☐ Heterosexual	☐ Mostly Gay /Mostly Lesbian	☐ Bi-Sexual	☐ Gay/Lesbian	☐ Unsure / Questioning

EMPLOYMENT STATUS: Employed ☐ Unemployed ☐ Retired ☐

If employed, please provide the name of your current employer: _____

What is/was your position title at your current or last job? _____

How long have/did you work for your current/last employer? _____

Medication Log (If applicable)

Client 1

Name:	**Allergic To:** *(Describe reaction)*
Emergency Contact/Phone numbers:	
Doctor(s): and contact info:	

List all medicines you are currently taking. Include prescriptions (examples: pills, inhalers, creams, shots), over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin, inhalers).

START DATE	NAME OF MEDICATION	DOSE	DIRECTIONS *(How do you take it? When? How often?)*	DATE STOPPED	NOTES *(Reason for taking?)*

Client 2, if applicable

Name:	**Allergic To:** *(Describe reaction)*
Emergency Contact/Phone numbers:	
Doctor(s) name and contact info:	

List all medicines you are currently taking. Include prescriptions (examples: pills, inhalers, creams, shots), over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin, inhalers).

START DATE	NAME OF MEDICATION	DOSE	DIRECTIONS *(How do you take it? When? How often?)*	DATE STOPPED	NOTES *(Reason for taking?)*
sar	sar	sar	sar	sar	sar

PROFESSIONAL DISCLOSURE STATEMENT
Thomas L. Murray, Jr., Ph.D., PLLC
www.TriadSexpert.com

Qualification/Areas of Practice

I am pleased you have selected me as your mental health provider. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I hold the following degrees:

- Ph.D. in Marriage and Family Counseling (Counselor Education), University of Florida – 2005
- Ed.S. in Marriage and Family Counseling, University of Florida – 2001
- M.Ed. in Marriage and Family Counseling, University of Florida – 2001
- B.S. Ed. in Secondary Education-Social Studies, Bloomsburg University of Pennsylvania – 1999

I am licensed as a Marriage and Family Therapist (1101) and Professional Counselor Supervisor (5025S) in the State of North Carolina. I am also certified by the National Board for Certified Clinical Hypnotherapists (3168), the National Board of Forensic Evaluators, Inc. (000052), and by the American Association of Sex Educators, Counselors and Therapists as a **Certified Sex Therapist**. I have been practicing counseling since 2001, and my services are limited to following areas:

Individual, Couples and Family Counseling	**Compulsive Behavior (e.g., Internet, Shopping, Gambling, Sex, etc.)**	**Chronic Physical Illness & Mental Health (Psychoneuroimmunology)**
Stress Management (Hypnosis, biofeedback)	**Men and Women Issues**	**Psychiatric Drug Discontinuation Support and Education**
Anxiety Disorders	**Dream Analysis**	**Death & Dying**
Life Transitions (Divorce, Parenting, etc.)	**Sexuality; Sex Therapy**	**Psychoeducational Evaluations (add'l fees apply)**
LGBTQ	**Grief, Loss, & Trauma (PTSD, EMDR)**	**Medical Family Therapy**
	Mood Disorders	

Nature of Counseling

Two major philosophical tenets inform my practice. First, I practice from an ecosystemic framework. This approach contends that thoughts, emotions and behaviors are contextual, meaning that thoughts, emotions and behaviors (or symptoms) must be understood within the context of the relationships and culture in which they exist. Therefore, I take a non-blaming and non-pathologizing approach to my clinical work. I strive for clients to understand the context for the development of the symptom(s) and develop strategies that strengthen the health and wellbeing of the person and family, while using the least invasive approaches possible. Secondly, I emphasize the Client-Directed, Outcome Informed approach, which means that (a) client feedback is routinely sought and used to direct the counseling session, and (b) the progress towards the amelioration of symptoms is routinely measured and the results are used to determine the effectiveness of the counseling relationship. Despite my best attempts, there are no absolute guarantees that you, specifically, will find my services helpful. However, research suggests that those in psychotherapy are better off than 80% of those who do not seek treatment.

If a clinical diagnosis is required for third-party reimbursement, the process of assigning a diagnosis is best performed collaboratively. Please note that a diagnosis is short-hand for a set of behavior and that psychiatric diagnoses suffer from poor reliability within a clinical setting. Diagnoses should <u>not</u> be construed as evidence of a brain defect, genetic defect, or chemical imbalance (unless a true brain disease process exists, e.g., Alzheimer's, tumor, stroke, etc.). Because I am not a medical doctor, I cannot ethically or legally make such inferences. I do not prescribe medication, although a referral to a prescribing professional will be made upon request or when clinically indicated. .

Our sessions will address one or more of the concerns identified in the bulleted list above. Sessions consist of 45-50 minutes for individuals. Couples, family, and group counseling sessions range between 45 to 90 minutes.

Risks

There are risks to psychotherapy. The first and most important one is that people often feel worse as the therapy progresses. Therapy can complicate your life. After all, you may discover that you have feelings about people that you never realized you had. You may want or need things you had overlooked and may not have access to them yet. You may have had experiences in the past that must be reconciled, and sometimes that is cumbersome. *Couple therapy without both partners may increase the risk of separation and divorce.* Therapy may result in a sense of memories that depict abusive episodes; these memories should not be automatically construed as fact since memories can be created after the fact (i.e., confabulated).

Some clients develop strong feelings about their therapists. Please do not offer gifts or ask me to relate to you in any other manner than the professional context of our counseling sessions. I do not accept "friend requests" or contact requests on social media. You will be best served if our relationship remains strictly professional and if our sessions concentrate exclusively on your concerns. You will learn about me as we work together during your counseling experience. However, it is important for you to remember that you are experiencing me only in a professional role. Please note that in order to protect your confidentiality, I treat you anonymously in public unless you initiate public interaction.

Initial

Referrals and Complaints

If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, I will provide you with a minimum of three referrals to other local clinicians. I am not responsible for care received from professionals to whom I might refer you. Our agreements do not involve other providers in the suite, who operate solo independent practices. (We are not a group practice.). You may report complaints to the following agencies: (1) North Carolina Board of Licensed Professional Counselors at NCBLPC, P.O. Box 77819, Greensboro, NC 27417; 844-622-3572; (2) NC Marriage & Family Licensure Board (NCMFTLB), PO Box 37669, Raleigh, NC 27627; 919-772-6600.

Fees, Insurance Reimbursement and Cancellations

Fees range from $140-240, and sessions range from 45-90 minutes. (**Initial evaluation for Individuals, Couples and Families**: $240, 90-min; **Individual sessions**: $140, 45-50 min; **Follow-up Couples sessions**: $200, 90 min.). Fees are due and must be paid at the conclusion of each session. Cash, credit card or personal checks are acceptable forms of payment. **Cancellation**. In the event that you are not able to keep an appointment, you must notify me 24 hours in advance, except for medical emergencies. Insurance will not pay for missed sessions. You may be charged a fee if you are more than 15 minutes late, as insurance cannot be billed for this time. If I do not receive such advance notice, you will be responsible for paying for the missed session, which includes allotment from bulk purchases, if applicable. **Insurance**. If I am a provider with your plan, I will submit claims for you. You are responsible for any copays/deductables associated with your plan. If I am NOT a provider for your plan, you agree to pay the full rate associated with that session. I can give you an invoice so that you can seek reimbursement from your plan.

PLEASE SIGN IF USING YOUR INSURANCE

"I authorize the release of any information necessary (including notes, treatment summaries/records and diagnosis) to my insurance plan to process claims, determine medical necessity, or to request additional services. I understand that a psychiatric diagnosis must be assigned and will become a part of my permanent medical record. I understand that certain diagnoses could impact my access to such things as private disability insurance, employment opportunities, etc."

(Sign here) : X_____

(If applicable, second client sign here):_____

"**I authorize payment of benefits to my provider**." (Sign here): X_____

Records and Confidentiality

All communication, including diagnoses, becomes part of the clinical record, which is accessible to you upon request (unless doing so would be psychologically harmful). I will keep confidential anything that you say to me, with the following exceptions: a) you direct me to tell someone else (with an appropriate signed release), b) I determine that you pose an imminent danger to yourself or others, c) I am ordered by a court to disclose information, d) I suspect abuse of a child, elder person or a developmentally delayed person, e) I am collaborating with one of your healthcare providers where disclosure of personal information is necessary to provide optimal care, and/or f) you are a minor for whom confidentiality is limited to the extent exercised by your parent/legal guardian or DSS worker/guardian ad litem (if applicable). When doing couples and family counseling, I should not be asked to withhold specific information from other members of the family/system as it is difficult to guarantee adherence to the request.

By signing below, I and/or my legal guardian (a) consent to counseling and (b) understand the risks, benefits, procedures, and limitations of mental health counseling as described above. All of my questions and/or my legal guardian's questions have been answered to satisfaction. **(For minors with divorced parents, if custody arrangements are such that require both parents' signatures, please include all necessary signatures below.)**

By your signature below, you indicate that you read and understood this statement**,** permit the use of audio or video recording, and acknowledge receipt of my *Notices of Privacy Practices*. My *Notice* provides information about how I may use and disclose your private health information. I encourage you to read it in full. My *Notice of Privacy Practices* is subject to change. If I change my *Notice*, I will make a copy available. Finally, your signature below indicates that any questions you have about this statement have been answered completely and to your satisfaction.

#1 Client Signature Name Date	#2 Client Signature Name Date	#1 Client Signature Name Date (For minors only)
#1 Client's Printed Name	#2 Client Printed Name	#3 Client Printed Name (For minors only)
Thomas L. Murray, Jr, PhD		☐ Please initial if you would like a copy of this signed document.

Thomas L. Murray, Jr., PhD, PLLC **CREDIT CARD AUTHORIZATION**

If you have questions or concerns regarding any part of this fee structure or billing/payment policies, please discuss these with me as soon as possible. This form will be securely stored in client's clinical file and updated upon request at any time.

Below is necessary even if you do not intend to use a cc payment so we may have a back up for any missed session fees, forgotten payments, etc. (A deposit check in the amount of one full session can be left in lieu of credit card information.)

By signing this agreement, I am authorizing Thomas L. Murray, PhD, PLLC to bill my credit card for professional services rendered to the "Client" that are not paid at the time of service, or for situations which fall under the late cancellation policy. Please note, insurance does not cover late cancellations or no-show. You are responsible for full fee timeslots. I agree that I will not dispute valid charges, which may include:

- A missed session fee of $100-140.00 depending on length of session scheduled, when the client has not cancelled or rescheduled with 24 hrs. notice, as outlined in the cancellation policy, or full fee if client does not show for an appointment and has not confirmed a cancellation.

- Telephone contact in excess of that usually associated with services, prorated at my regular hourly rate, with prior notice given before any charges are incurred, this may include phone contact in excess of 15 min. or completing forms such as medical/FMLA per your request.

- Checks that are returned will incur the check amount and an additional $25 bank fee

☐ Visa ☐ MasterCard ☐ Discover ☐ AM Is this an HRA/HSA type cc? No

Number:_____ Expiration Date: _____

Name as Printed on Card: _____

ZIP CODE: _____ CVV Code

Signature _____ Date _____

Please **initial e**ach of the following authorizing:

___ Recurring charges for services per visit outlined in fees policy. I may opt out at any time by using cash or a check.

___ $100-140 (see above). Cancellation fee for less than 24 hrs. confirmed notice; or if a session is missed without notice the full fee for the type of session scheduled (i.e., initial assessment, $240; 50 minute session, $140; 90 minute session, $200; prices are subject to change) will be charged.

____ I will not dispute legitimate charges for sessions I have received, appointments missed or without confirmation of confirmed 24 hrs notice, or charges due to a returned check.

_____ Balances not paid within 7 days will be charged on the Credit Card.

How Did You Hear About Us?

Thank you for choosing Thomas L. Murray, Jr., PhD, PLLC.
We would appreciate you taking the time to complete this form.
Please select one of the following

Did you hear about us in the one of the following ways:

- ☐ *Community Seminar/Event*

- ☐ *Newspaper Advert.*
- ☐ *Television*
- ☐ *Radio*
- ☐ *Intenet Search (other)*
- ☐ *Mail*
- ☐ *Yelp*
- ☐ *Psychology Today*
- ☐ *AASECT Website*
- ☐ *Business Card*

Whom may we thank for referring you to our practiced?

Provide Name and Address in this Section
and a Confidential Thank You Note will be sent

- ☐ *Doctor Referral*
- ☐ *Psychotherapist*
- ☐ *Friend*
- ☐ *Relative*
- ☐ *Employer*

Your signature: _____

PERMISSION FOR DIGITALLY RECORDING AND VIDEOTAPING THERAPY SESSIONS

Therapist's Explanation:

As a primary tool in Gottman Method Couples Therapy, and in order to augment your therapy work, I use videotape feedback as part of therapy sessions. This means that I may ask to videotape you during specific dialogues or exercises, or during entire sessions. We will play back these tapes in sessions to help you see patterns of behavior between the two of you and to help you process conflicts. By viewing the videotapes in sessions, it allows us to "stop action" and process how you might approach a conflict in a more productive way. It also allows you to witness your progress as your relationship becomes more satisfying to both of you.

In addition to in-session use, I may wish to use the videotapes to receive consultation from Drs. John or Julie Gottman or an independently practicing clinician who has received training from The Gottman Institute, or to provide such training. This may occur during the time of treatment or thereafter for purposes of peer review, education and quality assurance. During this process, your name will be kept confidential. In addition, all matters discussed in consultations will remain completely confidential within the Gottman Institute staff. The videotapes are not part of your clinical record and will be used for no other purpose without your written permission and they will be erased when they are no longer needed for these purposes.

These tapes are my property and will remain solely in my possession during the course of your therapy. Copies may be sent to the Gottman Institute for the purposes noted above. Should you wish to review these tapes for any reason, we will arrange a session to do so. These materials will remain in locked facilities at all times.

Clients' Agreement

I understand and accept the conditions of this statement and give my permission to have my therapy sessions videotaped or digitally recorded. I understand I may revoke this permission in writing at any time but until I do so it shall remain in full force and effect until the purposes stated above are completed.

Client _____ Date _____
(signature)

Client _____ Date _____
(signature)

Therapist _____ Date _____
(signature)

Thomas L. Murray, Jr., PhD, PLLC

Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *ACA Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a marriage and family therapist and professional counselor licensed in this state and as a member of the American Counseling Association (ACA), it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *ACA Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Dr. Thomas L. Murray, Jr. at 336-728-6066:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Dr. Thomas L. Murray, Jr. at 336-728-6066 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is February 15, 2016.