Trinity Counseling Center

Minor Intake Form

Office use only: Therapist:_____ DX: _____

Welcome to the Trinity Counseling Center. The information asked for below is to help us understand you and your concerns. Please fill out this form as completely as you can. All information will be held in strict confidence. Please note, all associates of TCC are independent contractors and TCC will only handle billing responsibilities.

How did you hear about us? (Check one)
□ Clergy persons □ Social Service Agency □ Family
□ Friend □ Employer □ Advertisement
□ School □ Former Client of TCC □ Physician or other
Please include specific name if appropriate. _____

Religious Affiliation: _____

Name of Minor: _____
Sex:□Male/□Female (Last) (First) (Middle)

Birth Date: _____ Age: _____ Grade: _____ School: _____ Teacher: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Telephone No.: Home: _____ Cell: _____ EMail: _____

Father's Name: _____ Date of Birth: _____

Address (if different than child's): _____

Father's Employer: _____ Occupation: _____

Work Phone: _____

Mother's Name: _____ Date of Birth: _____

Address (if different than child's): _____

Mother's Employer: _____ Occupation: _____

Work Phone: _____

Child Custody Clarification:

Marital or relationship status of mother: _____

Marital of relationship status of father: _____

Who has legal custody of the child? _____
(If custody documents have been issued (divorce or guardianship), a copy is needed for the file.

Brothers and sisters names and ages: _____

Has the child been in counseling before? □ Yes □ No If so, with whom? _____
Where? _____
Child's Physician's Name: _____
Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____

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When was your child's last medical exam? _____

Is your child currently on medication? □ Yes □ No

If so, what medication? _____

Major surgeries or illnesses in past five years? □ Yes □ No

For what condition(s): _____

Prescribed by: _____

Other health related conditions: _____

What do you believe your child's physical condition is at the present time? (Check one) □ Poor □ Fair □ Average □ Good □ Excellent

What do you believe your child's emotional condition is at the present time? (Check one) □ Poor □ Fair □ Average □ Good □ Excellent

Which of the following describe or relate to the concerns which bring you here:

□ Anger □ Anxiety □ Fearfulness □ Grief □ Self esteem □ Poor Appetite □ Sleep
□ Suicide □ Sexuality

Relationships with: □ Parents □ Siblings □ Friends □ School Staff □ Other: _____

State in your own words the concerns that bring you to therapy:

_____

_____

_____

What do you hope to achieve in therapy (your goals/expectations)?

_____

_____

_____

Would you like to receive information on our other activities and programs? □ Yes □ No

CONSENT FOR TREATMENT OF A MINOR

I am the parent/guardian of the above named minor. I hereby give permission for my child/adolescent to receive mental health assessment and therapy at Trinity Counseling Center of Southern Oregon. I further realize, in cases of divorce, my child's non-custodial parent may have rights, which include the disclosure of the case file. This consent is valid for one year.

_____ _____

(Parent/Guardian) **(Date)**

Trinity Counseling Center

Insurance Form

DISCLAIMER: By providing your insurance information you acknowledge TCC will bill your policy on your behalf, and any benefits quoted by our office or your insurance company is *not a guarantee of coverage*. Benefits will be determined by your insurance policy per session billed, and any non-covered charges will be the responsibility of the client. Client is responsible to update TCC if there are any changes to the policy listed.

This form is required for all clients who are covered by insurance, EAP, or managed care benefits.

1. Client's Name: _____

2. Name of Primary Insured: _____ D.O.B.: _____
   Address: _____ City: _____ State: _____ Zip: _____
   Telephone No.: _____ Male: _____ Female: _____

3. Relationship of Client to Insured: _____

4. Primary Insured's Employer (if group policy): _____

5. Employee ID/Policy # of Primary Insured: _____ Group Number: _____

6. Check one of the following: □ Health Insurance □ EAP □ Worker's Comp □ Automobile Insurance

7. Insurance Company: _____
   Address: _____ City: _____ State: _____ Zip: _____
   Telephone No.: _____

8. Is there another health benefit plan or insurance company providing coverage? □Yes □ No
   If Yes, complete the following:
   Name of Primary Insured: _____ D.O.B. _____
   Address: _____ City: _____ State: _____ Zip: _____
   Telephone No.: _____ Male: _____ Female: _____
   Other Insurance Plan Name: _____
   Address: _____ City: _____ State: _____ Zip: _____
   Telephone No.: _____
   Other Insured's Employer: _____
   Other Insured's Policy Number: _____ Group Number: _____

I hereby authorize the Trinity Counseling Center, Inc. and any member of the clinical staff of the Center to provide summary of care and assessment information regarding evaluation and/or treatment of (client's name) _____ for the purpose of evaluating and processing claims for benefits.

I further authorize payment of medical benefits to Trinity Counseling Center for services provided.

Signed: _____ Date: _____
Client/Parent/Legal Guardian

Trinity Counseling Center

FEE AGREEMENT

Our standard counseling fees are listed below. These fees can be paid in a number of ways.
Trinity Counseling Center accepts insurance reimbursements and payments from some Employee Assistance Programs. Clients with insurance coverage are expected to pay their co-pay or co-insurance payment to TCC prior to each counseling session, as well as all fees not covered because the insurance deductible amount has not been met. We accept Cash, Check and Credit Card Payments. **Payments are to be made payable to Trinity Counseling Center.**

CPT	Description	Fee
90791	Intake Session	$ 320.00
90837	Psychotherapy Session (52 min+)	$ 300.00
90834	Psychotherapy Session (45 min)	$ 250.00
90832	Psychotherapy Session (30 min)	$ 150.00
90847	Family Session w/client	$ 300.00
90839	Crisis Session (up to 60 min)	$ 320.00
90840	ADD ON: Add'l 30 min for Crisis	$ +150.00
90785	ADD ON: Interactive/Play Therapy	$ +30.00
96103	ADD ON: Computerized Testing	$ +175.00
MISSED	Canceled/Missed Appt w/o prior notice	$ 85.00

Office Use
Deductible: $_____
Coins %_____ / Copay $_____
Insurance UCR: $_____ (90791)
Insurance UCR: $_____ (_____)
Client Payment: $_____/session
Balance to bill (if applicable): $_____
CASH Fee: $ _____

Client Consent to Fee Agreement:

Initial

_____ I have read the above information and agree to the listed fees.
_____ I consent to being treated by the assigned counselor.
_____ I agree to pay the contracted fee at the time of service.
_____ I understand I will be responsible for paying missed sessions for which a 24-hour prior notice is not given, and my insurance company will not be billed*.
_____ I am fully responsible for all fees assessed to my account.
_____ If my insurance policy or another third-party coverage does not pay TCC for the services rendered, I am responsible for paying the full amount of the TCC fee (unless otherwise prohibited by insurance company regulations communicated to TCC as part of the authorization process).
_____ I understand fees for counseling are to be paid in advance, before my session, unless other arrangements have been made.
_____ Trinity Counseling Center has a legal right to utilize a collection service to collect payment if I fail to pay in full for services received, and to review services until such payment is made.
_____ I have read and understood the conditions upon which my fee has been determined, and I agree to these conditions.

_____ _____ _____
Client/Responsible Party Client/Responsible Party Date

TRINITY COUNSELING CENTER

NOTICE OF FEES FOR COURT/LEGAL PROCEEDINGS

September 1, 2017

If a therapist receives a subpoena or court order, or is requested to appear for any court proceedings and/or prepare supporting documentation, those services are not included in client's therapy session fees and not billable to insurance for reimbursement. The following fee schedule will be implemented for all legal services beyond the scope of client/therapist out-patient office visits.

All state and professional psychotherapist-patient privilege will be followed without exception. It is in the best interest of most clients to NOT request their therapist to appear or provide documentation in a court matter. The therapist is not an expert witness, and will only provide the court or legal representative with their professional opinion based on the information presented during therapy. No opinion as to custody will be given by the therapist: they are not a child custody evaluator. Only information that has been released by the client will be provided unless information is compelled into testimony by legal action. Even though the client is responsible for the testimony related fees, it does not mean any testimony will be solely in their favor. If a therapist is seeing a couple separately or a minor, requesting testimony can adversely affect the current therapeutic relationship. Therefore, we strongly discourage any client or related party to request testimony or psychotherapy records.

**Subpoena or notice to meet attorney(s) is to be served during office hours and with 72 hours notice. If notice is not given in that time frame, an additional $300 expedite fee will be applied.*

If a therapist is requested to participate in any legal proceedings, the following fees apply and will be assessed if therapist is scheduled for court on client behalf, and <u>is not contingent</u> upon any actual participation or testimony:

- Preparation Time (including submission of records) @ $220/hr
- Phone Calls: $220/hr
- Time required in giving testimony: $250/hr
- Mileage: $0.40/mile
- Time away from office due to depositions or testimony: $220/hr
- All attorney fees and costs that are incurred by the therapist as a result of the legal action
- Filing documents with the court: $100
- The minimum charge for a court appearance: $1500 (via cashier's check)

<u>A retainer of $1500 is due at least 72 business hours before the scheduled court appearance</u>.
The remainder of the costs will be billed after court appearance and will be due upon receipt. .
If the therapist is subpoenaed and the case is reset with less than 72 business hours notice prior to the beginning of the day of the scheduled subpoena, trial, and/or the testimony is not given, then the client will be charged $500 (in addition to original retainer of $1500 for having to appear in court)

If therapist has to change vacation plans due to scheduled appearance, all fees will be assessed at 200% of stated fees.

Client Signature_____ Date_____

Therapist Signature_____ Date_____

Electronic Communication Consent Form

1. Risk of Using Email and Text Communication

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

- Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Emails and text senders can easily misaddress an email or text and send the information to an undesired recipient.
- Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- Employers and online services have a right to inspect emails sent through their company systems.
- Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
- Emails and texts can be used as evidence in court.
- Emails and texts should be assumed to be unencrypted and, therefore, it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the Use of Email and Text Communication

- Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
- Email and texts should be concise. The client/responsible party should call and/or schedule an appointment to discuss complex and/or sensitive situations.
- Emails may be printed and filed into the client's medical record. Texts may be printed and filed as well
- Provider will not forward client's/responsible party's identifiable emails and/or texts without the client's/responsible party's written consent, except as authorized by law
- Clients/responsible parties should not use email or texts for communication of sensitive personal information
- Provider is not liable for breaches of confidentiality caused by the client/responsible party or any third party.

3. Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication using email and/or texts between associates of Trinity Counseling Center and me, and consent to the conditions as outlined, as well as any other instructions that may be imposed to communicate with me by email or text.

Client Name:_____ / SIGNATURE_____(required)

Email:_____ / Mobile #:_____ / DATE:_____

☐ I do NOT consent to the use of email or text message communications

☐ I have read this document in full and agree to the terms and conditions. (required)

By default, all client balance notices are sent via text or email. To receive a paper statement you must contact our office. Thank you.

Trinity Counseling Center – Client Rights and Responsibilities

Nondiscrimination Statement

Trinity Counseling Center and its providers comply with applicable federal and Oregon civil rights laws. We do not discriminate against, exclude, or treat people differently on the basis of race, color, national origin (including limited English proficiency), religion, sex, sexual orientation, gender identity, marital status, age, or disability.

We provide, free of charge:

- Language assistance, including qualified interpreters and information written in other languages.
- Aids and reasonable accommodations for people with disabilities, such as large-print materials or other accessible formats.

To request these services, or if you believe you have been discriminated against, contact **Gabriel Mccoy** at (541) 245-2787, 815 E. Jackson St., Medford, OR 97504.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, 200 Independence Avenue SW, Washington, D.C. 20201; 1-800-368-1019; or online at www.hhs.gov/ocr/complaints.

Your Rights as a Client

As a client, you have the right to:

- Receive a prompt, confidential, and respectful response from a trained professional.
- Know where you are in the treatment process, including the probable length of treatment.
- Obtain a copy of your treatment plan.
- Know the fees and billing procedures before services begin.
- Request a different therapist after discussing the request with your current therapist. If you disagree with your therapist's decision, you may meet with the **Clinical Director**.
- Have your records kept secure and shared only as described in our Notice of Privacy Practices.
- Refuse treatment, unless treatment is court ordered, without losing the right to other appropriate treatment if available. This includes the right to know what may happen if you do not accept treatment.
- See and get a copy of the information in your record. To do so, make arrangements with your therapist or submit a written request through our office.
- Submit complaints about services to the **Clinical Director**. You may also contact your provider's Oregon licensing board; your provider will give you that board's contact information.
- Receive services free from discrimination, as described in the Nondiscrimination Statement above.
- Privacy and confidentiality, within the limits described below.

Limits of Confidentiality

What you share in counseling is kept confidential, except in these situations:

- Reporting suspected abuse or neglect of a child, elder, or vulnerable adult, as required by Oregon law.
- Reporting imminent danger of a client harming themselves or others.
- Providing information required in court proceedings, by your insurance company or other payer, or by other agencies as required by law.
- Consultation or supervision between your provider and other licensed professionals.
- Defending against claims brought by a client against the provider.
- Reporting a client's stated intent to commit a crime that would result in harm to others.

Our Notice of Privacy Practices describes in more detail how your information may be used and shared.

Your Responsibilities as a Client

As a client, you are responsible for:

- Keeping appointments, or canceling at least 24 hours in advance.
- Telling your therapist about medications you take and other health care you receive.
- Paying your bills, and telling your therapist and the front office about changes in your insurance, financial situation, address, or phone number.
- Taking an active part in planning your treatment.
- Reviewing your progress in treatment with your therapist.
- Letting your therapist know if you plan to end treatment, ideally by scheduling a final session to discuss it.

Acknowledgment

I have read and received a copy of Trinity Counseling Center's Client Rights and Responsibilities, including the Nondiscrimination Statement and Limits of Confidentiality.

Client name (print): _____

Client signature: _____ Date: _____

If signed by a parent, guardian, or personal representative:

Name (print): _____ Relationship to client: _____

Signature: _____ Date: _____

Provider name: _____

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-541-245-2787 (TTY: 711) or speak to your provider.

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-541-245-2787 (TTY: 711) o hable con su proveedor.

Tiếng Việt (Vietnamese): LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-541-245-2787 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

简体中文 (Simplified Chinese):

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-541-245-2787（文本电话：711）或咨询您的服务提供商。

繁體中文 (Traditional Chinese):

注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-541-245-2787（TTY：711）或與您的提供者討論。

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-541-245-2787 (TTY: 711) или обратитесь к своему поставщику услуг.

Українська (Ukrainian): УВАГА: Якщо ви розмовляєте українською мовою, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-541-245-2787 (TTY: 711) або зверніться до свого постачальника.

한국어 (Korean): 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-541-245-2787(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

العربية (Arabic): تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-541-245-2787 (TTY: 711) أو تحدث إلى مقدم الخدمة.

Soomaali (Somali): FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-541-245-2787 (TTY: 711) ama la hadal bixiyahaaga.

Chuukese: ESINESIN: Ika en mi kan fos non Chuukese, mi kawor aninisin awewen fos ese kamo ngonuk. Mi pwan kawor aninisin ousening me aninisin maken non och nikinik epwe mecheres ngonuk ese kamo. Kekeri 1-541-245-2787 (TTY: 711) ika fos ngeni noumw ewe chon awora aninis.

فارسی (Farsi): توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-541-245-2787 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

አማርኛ (Amharic): ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-541-245-2787 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

ភាសាខ្មែរ (Khmer): សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃដងដែរ។ ហៅទូរសព្ទទៅ 1-541-245-2787 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

Kiswahili (Swahili): MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-541-245-2787 (TTY: 711) au zungumza na mtoa huduma wako.

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-541-245-2787 (TTY: 711) o makipag-usap sa iyong provider.

Notice of Privacy Practices

Effective date: 10/2026

This notice describes how medical and mental health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions, ask our office; we will answer them at no charge.

Who this notice covers. Trinity Counseling Center, LLC ("Trinity") provides administrative, billing, and office services for counseling providers who practice at Trinity as independent contractors. Each provider is licensed by the appropriate Oregon licensing board, carries their own professional liability insurance, and keeps and is responsible for the clinical records of the clients they treat. This notice is a joint notice that applies to Trinity's office and to each provider practicing at Trinity. In this notice, "we" and "us" refer to Trinity's office and your provider together.

Our Responsibilities

Federal law (HIPAA) and Oregon law require us to protect the privacy of your health information. We are required to:

- Keep your health information private and secure.
- Give you this notice of our legal duties and privacy practices, and follow the terms of the notice currently in effect.
- Notify you promptly if a breach occurs that may have compromised the privacy or security of your information.

We may change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available on request, in our office, and on our website if we have one.

How We Use and Share Your Information

We may use and share your health information, verbally, in writing, or electronically, for the following purposes without your written authorization.

Treatment. Your provider may share information with other health care providers who are also treating you, such as your physician or psychiatrist, and with Trinity associates involved in your care.

Payment. Trinity's office handles billing for services you receive. This means the office receives the information needed to bill you or your insurance, such as your name, dates of service, diagnosis codes, and the type of service provided.

Insurance requests and audits. Trinity's office is the billing entity that contracts with insurance companies and other payers and is financially responsible to them for claims. For that reason, insurers, Medicaid/OHP plans, and other payers may request records from Trinity's office to

support a claim, conduct an audit, or review whether services were documented properly. When this happens, Trinity's office will obtain the needed records from your provider and send only the information the payer is entitled to receive for that purpose.

Health care operations. We may use your information to run our practice, for example to supervise and evaluate providers, improve the quality of services, and meet licensing, credentialing, certification, and accreditation requirements.

Other Uses and Disclosures Allowed or Required by Law

We may also share your information without your authorization in these situations, sharing only what the situation requires:

- Required by law, including federal, state, or local laws and Oregon regulations.
- Abuse or neglect reporting. Providers are mandatory reporters and must report suspected abuse or neglect of children, elders, and vulnerable adults.
- Serious threat to health or safety. To prevent or lessen a serious and imminent threat to your health or safety or that of another person.
- Emergencies. To a family member, a person responsible for your care, or your personal representative in an emergency. If you are present, you will have a chance to object. If you are not present or cannot respond, your provider will use professional judgment and share only what is needed to respond to the emergency.
- Lawsuits and legal proceedings. In response to a court order, or a subpoena that meets legal requirements.
- Health oversight. To agencies that oversee health care, such as licensing boards, for audits, investigations, and inspections.
- Law enforcement. For limited law enforcement purposes permitted by law.
- Public health. For public health activities, such as preventing or controlling disease.
- Coroners and medical examiners, as permitted by law.
- Workers' compensation, as authorized by law.
- Specialized government functions, such as military, national security, or protective services, as permitted by law.

Uses That Require Your Written Authorization

We will not use or share your information for any purpose not described in this notice without your written authorization. Your written authorization is always required for:

- Psychotherapy notes. These are a provider's separate personal notes about counseling sessions. They are kept apart from the rest of your record, and most uses and disclosures of them require your authorization.
- Marketing, development, or public relations activities.
- Sale of your health information. We do not sell your information.

You may also authorize us in writing to share your information with anyone you choose, for any reason. You may revoke an authorization in writing at any time. Revoking stops future sharing but does not undo sharing that already happened under the authorization.

Your Rights

How to make a request. Your provider holds your clinical records. You may give a written records request to Trinity's office or directly to your provider. The office will forward requests to your provider, who reviews and authorizes the release of your records. Please name your provider on any request.

Right to see and get a copy of your records. You may ask in writing to inspect or get a copy of your health information, with limited exceptions. If your records are kept electronically, you may ask for an electronic copy. We will respond within 30 days.

Fees for copies. For copies of your own records, we may charge a reasonable, cost-based fee limited to the cost of copying supplies, labor for copying, and postage. We will tell you the fee in advance. Copies requested by third parties with your authorization, such as attorneys, may be charged according to Oregon law (ORS 192.563).

Right to ask us to correct your records. You may ask in writing that we amend information you believe is incorrect or incomplete. If we agree, we will update the record and notify people who received it, and anyone else you name. If we deny your request, we will explain why in writing, and you may add a written statement of disagreement to your record.

Right to request confidential communications. You may ask us to contact you in a specific way or at a specific place, such as only by mail or only on your cell phone. We will agree to all reasonable requests and will not ask why.

Right to request restrictions. You may ask us to limit how we use or share your information for treatment, payment, or operations. We are not required to agree, except in this case: if you pay for a service in full out of pocket, you may ask us not to share information about that service with your health insurer, and we must agree unless the law requires the disclosure.

Right to a list of disclosures. You may ask for a list of the times we shared your information in the past six years, other than for treatment, payment, operations, and disclosures you authorized. The first list in any 12-month period is free. We may charge a reasonable, cost-based fee for additional lists in that period.

Right to a paper copy of this notice. You may ask for a paper copy of this notice at any time, free of charge, even if you agreed to receive it electronically.

Right to choose someone to act for you. If you have a legal guardian or have given someone medical power of attorney, that person can exercise your rights and make choices about your health information.

Questions and Complaints

If you have questions about this notice, or believe your privacy rights have been violated, contact our Privacy Contact:

Name	Gabriel McCoy, LMFT, Clinical Director
Phone	(541) 245-2787
Fax	(541) 201-8103
Address	Trinity Counseling Center, 815 E. Jackson St., Medford, OR 97504

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, 200 Independence Avenue SW, Washington, D.C. 20201, by calling 1-800-368-1019, or online at www.hhs.gov/ocr/complaints.

We will not retaliate against you in any way for filing a complaint.

Acknowledgment of Receipt

I acknowledge that I received a copy of Trinity Counseling Center's Notice of Privacy Practices. I understand that my provider holds my clinical records, and that Trinity's office handles billing and may request records from my provider when an insurer or other payer requires them.

Client name (print): _____

Client signature: _____ Date: _____

If signed by a parent, guardian, or personal representative:

Name (print): _____ Relationship to client: _____

Signature: _____ Date: _____

Provider name: _____

Office.use.only¿If the client did not sign, describe the good-faith effort made to obtain the acknowledgment and the reason it was not obtained:

_____