***The Other Road Counseling PLLC***

***Ph: 970-573-1655***

***Fax #- 855-217-8024***

**Demographic Information**

***Client’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_\_\_\_\_\_***

***Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Home phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Form completed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Primary Insurance Information**

|  |  |
| --- | --- |
| **Primary Insurance:** | **Policy Holder Name:** |
| **Identification number:** | **Policy Holder DOB** |
| **Policy Group number:** | **Employer:** |
| **Policy holder SSN** |  |

*I authorize The Other Road Counseling PLLC to release any medical I authorize payment of medical payments to*

*or mental health information necessary to process. The Other Road Counseling PLLC for*

*I also request payment of government benefits to myself. Services.*

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_ Sign and Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Information**

|  |  |
| --- | --- |
| **Secondary Insurance:** | **Policy Holder Name:** |
| **Identification number:** | **Policy Holder DOB** |
| **Policy Group number:** | **Employer:** |
| **Policy holder SSN** |  |

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*I authorize The Other Road Counseling PLLC to release any medical I authorize payment of medical payments to*

*or mental health information necessary to process. The Other Road Counseling PLLC for*

*I also request payment of government benefits to myself. Services.*

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign and Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***The Other Road Counseling PLLC***

***Ph: 970-573-1655***

***Fax: 855-217-8024***

**Financial Agreement**

It is the policy of this office that payment in full expected at the time of services are rendered if any of the following circumstances apply:

* You are choosing to self- pay (do not have health insurance).
* Your clinician is not a participating provider with your insurance/managed care plan
* You do not wish to have your insurance billed or you have not given all the current/correct information to file an insurance claim.
* Your insurance benefits do not cover the services rendered.

**Health Insurance Policies:**

* Your co-payment will be processed following your session via Square. Credit Cards will be accepted as the form of payment. Checks are not allowed for co-pays.
* I certify that the financial information provided is true, accurate, and complete to the best of my knowledge, and further authorize, The Other Road Counseling PLLC to investigate any and all financial information given concerning this or related claims.
* I understand and agree to inform Mallorie Smolen LCSW at The Other Road Counseling PLLC of any changes to my insurance at time of service.
* Your insurance company may reimburse you for services received at The Other Road Counseling PLLC. If this should happen, any payments you receive must be signed and forwarded to The Other Road Counseling PLLC for services rendered to you by this clinician.
* Your insurance company only covers direct therapeutic services
* There is a 24-hour cancellation policy. If for any reason you need to cancel your session please call, or text 970-573-1655. Any scheduled appointment that is missed and/or not cancelled by the client more than 24 hours in advance will be charged a $50.00 missed session fee. This fee will be charged to your chosen credit card. I understand that emergencies occur, so please contact me as soon as possible. Special circumstances shall be discussed with this clinician. 3 consecutive cancellations will result in discharge. A referral will be provided.
* I understand that The Other Road counseling PLLC reserves the right to pursue delinquent accounts via third party collection agencies or attorneys and that I am responsible for any fees incurred by The Other Road Counseling PLLC, or its’ assigned, during the collection process, including reasonable attorney fees. If payments are not paid within 30 days, collections will be pursued.

***I have read and understand the financial agreement above. By my signature below, I agree to abide by the terms of the financial agreement, fully understand the release of information to my insurance company and agree to make all efforts to pay for the services rendered in a timely fashion. I authorize The Other Road Counseling PLLC to charge any fees that are not paid at the time of service to the following credit card:***

|  |  |
| --- | --- |
| ***Client Name:*** | ***Date of birth:*** |
| ***Credit Card Type*** | ***Card Number:*** |
| ***Expiration Date:*** | ***Security Code:*** |
| ***Signature of client:*** | ***Date:*** |
| ***Signature of clinician:*** | ***Date:*** |

***The Other Road Counseling PLLC***

***Ph: 970-573-1655***

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**Confidentiality**

* All client information is to be treated as confidential.
* The privacy and confidentiality of clients are protected under the Ethics Codes of the Mental Health Professions, state laws and regulations, and federal HIPPA Regulations.
* No client information may be disclosed without the explicit informed consent of the client and authorization by Mallorie Smolen, LCSW (The Other Road Counseling PLLC).
* If you report, or I have a reason to believe that you are an active perpetrator or victim of abuse (physical or sexual), molestation, or neglect, I am mandated to report this to the authorities. In addition, any abuse of clients over 65 years of age must also be reported to Elderly Protective Services 1-800-385-4052 (CT) and 1-970-498-7770 (CO)
* If a client states that they are going to harm themselves or others, I am required to notify your emergency contact or victims if I believe there is a real and imminent danger.
* If legally subpoenaed by a court of law, your treatment records must be available to the court.
* If a client files a compliant or lawsuit against me, I may disclose relevant information regarding the client in order to defend myself.
* If you are in therapy and /or being evaluated by a court of law, the results of your evaluation and/or treatment may be revealed to your probation officer or to the court.
* If you are a minor, your parents/legal guardians must be informed of your progress, if they request. However, they do not have to be told of all the details of our conversations.

Your health insurance carrier or managed care company may require sharing of clinical information including diagnosis, treatment plan, and progress notes in order to authorize and help coordinate your treatment.

I may occasionally find it helpful to consult with other mental health professionals. I also employ administrative staff at The Other Road Counseling PLLC. In most cases, I need to share information for the following purposes: clinical and administrative purposes; such as scheduling, billing, and quality assurance. All employees are bound by the same rules of confidentiality.

Every effort will be made to discuss with you a breach of confidentiality that is being considered and to resolve the issue to your satisfaction.

***I have had an opportunity to ask questions and receive answers regarding the above-mentioned statements. I have received a copy of the clients rights and responsibilities form. I authorize The Other Road Counseling PLLC to provide treatment as considered necessary and to share necessary clinical information with my health insurance carrier or managed care company when required as explained above.***

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Client’s name*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Client’s Signature Date*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Guardian's signature (if client is under 18) Date*

**Client Health Insurance Waiver**

I have requested services for therapy by Mallorie Smolen, LCSW at The Other Road Counseling PLLC.

No claim will be sent to my insurance company since it is my cliental decision to not use insurance benefits for therapy services even though I understand that these services are covered under my policy. (Elective self- pay).

Signature of Client Date

Printed Name and relationship of client Date

Authorized to sign for the client

Reason client is unable to sign:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Insurance Waiver explained by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Clinician Date

**Consent to Treat**

**Tele-behavioral Health:**

As a client receiving behavioral services through tele-behavioral health technologies, I understand:

Tele-behavioral health is the delivery of counseling and case management services, using interactive technologies (use of audio, video, or other electronic communications) between a therapist and a client who are not in the same physical location.

The interactive technologies used in tele-behavioral health incorporate network and software security protocols to protect the confidentiality of the client’s information transmitted via electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

**Software Security Protocols:**

Electronic systems used will incorporate and software protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against unintentional corruptions.

**Benefits and Limitations:**

This service is provided by technology (including Zoom, Drop Box, video, phone, text, and email) and may not involve physical face to face communication.

This service includes the following benefits:

* Expands access and convenience
* Stigma of seeking treatment
* Cultural Competence
* Saves time
* Shortens delays

This service includes the following disadvantages:

* Some insurance companies will not cover tele-behavioral health services
* Concerns about confidentiality, privacy, and unreliable technology
* Online therapy is not appropriate for those with serious psychiatric illnesses
* Ethical and legal concerns pose potential problems.

**Technology requirements:**

I will need access to, and familiarity with, the appropriate technology in order to participate in the services provided.

**Exchange of information:**

The exchange of information will be through telephone, fax, or through postal delivery. Emails are sent through a HIPAA compliant platform called Hushmail. Drop box may be used for sharing of resources.

**Local practitioners:**

If a need for direct, in client services arises, it is my responsibility to contact practitioners in my area, Colorado Crisis line, 2-1-1 (experiencing a clinical emergency, or 9-1-1 (head to your nearest emergency room)

**Self-termination:**

I may decline any tele-behavioral health services at any time without jeopardizing my access to future care, services, and benefits.

**Emergency situations:**

If a emergency situation occurs contact this clinician immediately, 2-1-1, and 9-1-1 (head to your local emergency room). If this clinician is not available please contact 2-1-1 or 9-1-1 immediately.

**Clinician communication:**

I will respond to all emails, texts, and voicemails within 24 hours.

Square will send appointment reminders (which will include PHI information).

**Client communication:**

It is my responsibility to maintain privacy on my end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

**Laws and Standards:**

The laws and professional standards that apply to client behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

**I have read this informed consent document and abide by the above statement. I have had the opportunity to ask questions regarding my informed consent. I hereby give my consent to the treatment considered necessary by Mallorie Smolen, LCSW at The Other Road Counseling PLLC. I certify that if the client being treated is under the age of 18 years old that I am the legal guardian of the client.**

**I permit the use of a copy of this authorization as an original.**

Signatures:

Client printed name

Signature of Client or Legal Guardian Date

Witness Date

**Notice of Privacy Practices**

**HIPPA Receipt and Acknowledgment of Notice**

**Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby acknowledge that I have received and have been given the opportunity to read a copy of The Other Road Counseling PLLC Notice of Privacy Practices. I understand that if I have any questions regarding the notice of my privacy rights, I can contact Mallorie Smolen LCSW (The Other Road Counseling PLLC) at 860-208-3996. You will be provided a copy of the privacy practices.

**Signature of Client Date**

**Signature of Parent, Guardian, or Representative Date**

If you are signing as representative of an individual, please describe your legal authority to act for this individual (power of attorney etc).

**Client Refuses to Acknowledge receipt:**

**Signature of Administrative Staff Date**

**Notice of Privacy Practices**

**Mallorie Smolen, LCSW The Other Road Counseling, PLLC**

**Phone- 970-573-1655** Fax **855-217-8024**

**Effective Date: December 1, 2018**

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

**Commitment to Your Privacy:**

I am required by law to provide you with this notice that explains my privacy practices with regards to your medical information and how I may use and disclose your protected health information (PHI). In conducting business, I will create records regarding you and the treatment and services that I provide to you. I am required by law to maintain the confidentiality of health information. I also am required by law to provide you with this notice of my legal duties and the privacy practices. By federal and state law, I must follow the terms of the Notice of Privacy Practices that I have in effect at this time.

**The terms of this notice apply to all records containing your PHI that are created or retained by my practice. I reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that my practice has created or maintained in the past, and for any of your records that I may create or maintain in the future. I will provide a copy of the Privacy Practices on my website and you may request a copy of the most current notice at any time.**

**If you have questions about this Notice, please contact:**

Mallorie Smolen at The Other Road Counseling PLLC (970-573-1655).

**Uses and Disclosures of PHI:**

The following categories describe the different ways in which I may use and disclose your PHI:

1. **Treatment.** I may use and disclose your PHI to provide, coordinate, or manage your mental health treatment. I may also disclose your health information to other health care providers who may be treating you. For example, I may need to discuss medication or treatment concerns with your psychiatrist, doctor, or APRN; I may need a release of information to obtain pre-certification for your treatment; I may need to complete and submit outpatient treatment reports to your insurance company to obtain additional sessions.
2. **Payment.** I may use and disclose your PHI to bill and collect payment for the services I provide you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide you PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

**Health Care Operations.** I may use and disclose your PHI to support and operate my practice. For example, I may use your PHI to review and evaluate your treatment and services or to evaluate my performance while caring for you. In addition, I may disclose your health information to third party business associates who perform billing, consulting, transcription, or other services for my practice. I also employ administrative staff at The Other Road Counseling PLLC. In most cases, I need to share information for the following purposes: clinical and administrative purposes; such as scheduling, billing, and quality assurance. All employees are bound by the same rules of confidentiality.

1. **Appointment Reminders.** I may use and disclose your PHI to contact you as a reminder about scheduled appointments or treatment.
2. **Treatment Alternatives.** I may use and disclose your PHI to tell you about or recommend possible alternative treatments or options that may be of interest to you.
3. **Others Involved in Your Care.** I may use and disclose your PHI to a family member, a relative, a close friend, or any other client you identify that is involved in your medical care or payment for care.
4. **As Required by Law.** I may use and disclose your PHI when required to by federal, state, or local law.

**Use and Disclosure of PHI in Special Circumstances:**

The following describe unique scenarios in which I may use or disclose your PHI:

1. **Public Health Risk.** I may use and disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
   * Reporting child abuse or neglect,
   * Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult client (including domestic violence); however, I will only disclose this information if the client agrees or I am required or authorized by law to disclose this information,
   * Prevent or control abuse of neglect
   * Report reactions to medications or problems with products
   * Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health Oversight Activities.** I may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include: audits, investigations, inspections, and licensure.
3. **Lawsuits and Similar Proceedings.** I may use and disclose your PHI in response to a court or administrative order, if you have a signed release of information. If you are involved in a lawsuit or similar proceeding. I also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if efforts have been made to tell you of the requests or to obtain an order protecting the information the information requested.
4. **Law Enforcement.** I may release PHI if asked to do so by a law enforcement official:
   * Regarding a crime victim in certain situations, if I am unable to obtain the client’s agreement,
   * Concerning a death I believe has resulted from criminal conduct,
   * Regarding criminal conduct at our offices,
   * In response to a warrant, summons, court order, subpoena or similar legal process,
   * To identify/locate a suspect, material witness, fugitive or missing client,
   * In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).
5. **Military.** I may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. **National Security.** I may disclose your PHI to federal officials for intelligence and national security activities authorized by law. I also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
7. **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, I may release medical information about you to the correctional institution or law enforcement official only if authorization to release information is obtained. This release would be necessary 1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; of (3) for the safety and security of the correctional institution.
8. **Workers’ Compensation.** I may release your PHI for workers’ compensation and similar programs. Similar programs include but are not limited to; short term and long term disability.

**Your Rights Regarding Your PHI:**

1. **Confidential Communications.** You have the right to request that I communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that I contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Mallorie Smolen, LCSW at The Other Road Counseling, PLLC (970-573-1655) specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions.** You have the right to request a restriction in my use or disclosure of your PHI for treatment, payment, or health care operations. Additionally, you have the right to request that I restrict my disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. I am not required to agree to your request; however, if I do agree, I am bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in my use or disclosure of your PHI, you must make your request in writing to Mallorie Smolen, LCSW at The Other Road Counseling, PLLC (970-573-1655) Your request must describe in a clear and concise fashion:
   * The information you wish restricted,
   * Whether you are requesting to limit my practice’s use, disclosure or both,
   * To whom you want the limits to apply.
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Mallorie Smolen, LCSW at The Other Road Counseling, PLLC (970-573-1655) in order to inspect and/or obtain a copy of your PHI. I may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. My practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by me will conduct reviews.
4. **Amendment.** You may ask me to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by myself. To request an amendment, your request must be made in writing and submitted to Mallorie Smolen, LCSW at The Other Road Counseling, PLLC (970-573-1655). You must provide me with a reason that supports your request for amendment. I will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, I may deny your request if you ask me to amend information that is in my opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; not part of the PHI which you would be permitted to inspect and copy; or (d) not created by my practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures.** Clients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures that has made of your PHI for purposes not related to treatment, payment, or operations. Use of your PHI as part of the routine client care in my practice is not required to be documented. For example, the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Mallorie Smolen, LCSW at The Other Road Counseling, PLLC (970-573-1655). All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before December 1, 2018. The first list you request within a 12-month period is free of charge, but my practice may charge you for additional lists within the same 12-month period. I will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of this Notice.** You are entitled to receive a paper copy of my notice of privacy practices. You may ask me to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Mallorie Smolen, LCSW at The Other Road Counseling, PLLC (970-573-1655)
7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with my practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Mallorie Smolen, LCSW at The Other Road Counseling, PLLC (970-573-1655). All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to Provide an Authorization for Other Uses and Disclosures.** I will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to me regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, I will no longer use or disclose your PHI for the reasons described in the authorization. Please note: I am required to retain records of your care.

**Privacy Officer Information:**

If you have any questions regarding my notice of privacy policies, complaints about my privacy practices, or need information on how to file a complaint, please contact Mallorie Smolen, LCSW at The Other Road Counseling, PLLC (970-573-1655).

Contact Officer: Mallorie Smolen, LCSW

P: 970-573-1655

Fax: **855-217-8024**