M. Elicia Nademin, Ph.D.

*3040 E Cactus Rd. * Suite A * Phoenix, AZ 85032*
*(O) 480-221-8816 * (F)* **602-494-3131** *** www.aztherapeutic.com**

PSYCHOLOGIST-CLIENT AGREEMENT

Welcome to my practice! This document (the Agreement) contains important information about my professional services and policies. It is intended to help my clients understand how the business office operates with respect to the psychologist-client relationship. Please read all of the information herein and ask me any questions you may have. Your signature on this document will represent an Agreement between us. You may revoke this Agreement in writing at any time, and that revocation will be binding unless a) I have taken action in reliance on it; b) your health insurer imposes obligations on me in order to process or substantiate claims made under your policy; or c) you fail to satisfy any financial obligations you have incurred.

Psychological Services

Psychotherapy, as I practice it, varies depending on the personalities of the psychologist and client, the therapist's training and treatment philosophy, and the client's specific needs. My approach to psychotherapy is generally characterized as cognitive-behavioral therapy. In the interest of informing optimal treatment, however, I integrate skills from various approaches. Throughout treatment, I may ask you to work on things we talk about both during session and at home. Unlike a medical appointment, psychotherapy requires a very active engagement on your part and offers few guarantees. It can have benefits and risks. Since therapy often involves discussion of unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, anxiety, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy also offers hope of many benefits, leading to solutions to specific problems, significant reductions in feelings of distress, better relationships, and an enhanced quality of life. My assessment normally occupies the bulk of the first session. During this intake session, we can both decide if I am the best person to provide the services needed to meet your treatment goals. If we agree to proceed, I will generally schedule weekly 45-minute sessions (i.e., "therapeutic hour"). Sessions may become less frequent as therapy continues.

One of the most vital elements of psychotherapy is the therapeutic relationship. My hope is that you will feel comfortable working with me and safe disclosing to me; trust and rapport are crucial to this process. Therapy involves a significant commitment of time, money, and energy, so choosing a therapist who is a good fit is important. If after we meet you have questions, doubts, or misgivings, I encourage you to communicate these to me as they arise, so that we may discuss them and make modifications to our plan, if fitting. If your doubts persist, I will be happy to offer you referral options for an alternative mental health professional, if desired.

Cancellations

Once an appointment is scheduled, you are expected to pay for it unless you provide at least 24 hours advance notice of cancellation or rescheduling (or we both agree that you were unable to attend due to circumstances beyond your control). If you are running late to a session, please call me ASAP to let me know. If you arrive late and we proceed with the session, you will still pay for the full session fee; however, we will end at our previously scheduled end-time. If I am late, I will extend our session time accordingly. **If you are over 15 minutes late and I do not hear from you, I will consider the session cancelled, and you will be charged.** Please note that if you plan to submit claims for insurance reimbursement, insurance companies do not provide reimbursement for cancelled sessions. If you miss two consecutive sessions, we will discuss whether the timing for therapy is convenient for you. **If I am unable to reach you to discuss rescheduling, and six weeks lapse from the time of our last contact, your chart will be closed. I will happily reopen your file, however, if you express interest in later resuming services**. While you may discontinue therapy at any time, you will be responsible for payment of all services rendered.

Contacting Me

My apologies, in advance, but I am often not immediately available by telephone, nor do I provide emergency services. Messages, which are monitored nightly, can be left for me at the front desk or by voicemail, and I will make every effort to return calls within 24 hours, barring extenuating circumstances. Please leave a callback number with all messages, as I may retrieve messages while away from the office. I can be contacted directly by e-mail at eliciaphd@gmail.com for scheduling/administrative purposes. **Please note, however, that e-mail is not a confidential form of communication nor appropriate for urgent messages.** Thus, in an effort to protect your privacy, I encourage you to refrain from including sensitive clinical information over e-mail. If you feel that you cannot wait for me to return your call, please contact your family physician or the nearest emergency room. In a crisis, you may call EMPACT 24-hour crisis hotline at 480-784-1500 and/or Magellan Crisis Lines at 602-222-9444 or 800-564-0546. In the event of an emergency, please call 9-1-1. If I will be unavailable for an extended period of time, I will provide you with a colleague's name to contact, if necessary.

Confidentiality Policy

Please see separate form on clients' privacy practices**.**

Limits on Confidentiality

In general, the law protects the privacy of all communications between a client/patient and psychologist or other health care professional, and I can only share information about our work together to others with your written permission. To ensure the highest quality of care, I may sometimes confer with other health professionals about your treatment. I generally make every effort to avoid revealing your identity; however, if potentially identifiable or more detailed information is necessary, I will only release information about you with a written and authorization form signed by you, consistent with legal requirements imposed by HIPAA. This legal "Authorization" for release/exchange of information will remain in effect for a period of time, as designated by you. You may revoke the authorization at any time, unless I have taken action in reliance on it. Please also note that I practice with other professionals who may also be privy to your Protected Health Information (PHI) for administrative purposes, such as scheduling, billing, and quality assurance. These persons along with professionals with whom I exchange information about you are likewise bound by the rules of confidentiality not to release any information about you without appropriate consents.

I may be permitted or required by law to contact appropriate agencies and disclose information without your consent or authorization if:

- Health insurance companies require treatment information to authorize payment for services or for collection of overdue fees, as discussed in this Agreement.
- You are involved in legal proceedings, and a request is made under a court order for information concerning professional services I provide you. My policy to try to reach you before releasing any information, if a subpoena is received. (Note: If you are involved in or contemplating litigation, you are advised to consult with your attorney to determine whether a court would be likely to order me to disclose information.)
- A government agency requests information for health oversight activities.
- You file a complaint or lawsuit against me, and I must disclose information about you to defend myself.
- If you file a worker's compensation claim, and I am providing services related to that claim. I must provide relevant reports to the Workers Compensation Commission or insurer upon appropriate request.

In some situations, I am legally obligated to take actions I believe necessary to protect others from harm. These situations may require me to reveal information about your treatment. While rare in my practice, these include:

- If I have knowledge or reason to suspect that a child under the age of 18 whom I have examined is or has been the victim of injury, sexual abuse, neglect, or deprivation of necessary medical treatment, the law requires that I file a report and follow-up, as necessary, with the appropriate governmental agency, usually the Office of Child Protective Services. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that any adult who is either vulnerable and/or incapacitated has been the victim of mental, physical, or sexual abuse; neglect; or financial exploitation, the law requires that I file a report with

the appropriate state official, usually a protective service worker. Once such a report is filed, I may be required to provide additional information.

- If you communicate an explicit threat of imminent and serious injury to self or another individual, or if I believe that you present as a substantial risk of such, I may be required to take protective actions, including notifying individuals who can protect you and/or others. Such actions may include initiating emergency hospitalization, contacting the police, and/or notifying the potential victim (in the event of threat to other).

If such situations arise, I will make every effort to discuss options with you before taking any action; I will limit disclosure(s) to the minimum necessary for reporting. It is important that we discuss any questions or concerns you may have about these limits to confidentiality. However, because the laws governing confidentiality can be quite complex and I am not an attorney, legal advice may be warranted when specific advice is desired.

Minors and Parents

Clients under the age of 18 who are not emancipated and their parents should be aware that the law may allow parents to examine their childrens' treatment records. Because privacy in psychotherapy is crucial to progress, I often request verbal consent from parents to relinquish their access to their childrens' records. If they agree, I will provide them only with general information about the progress of their child's treatment and his/her attendance at scheduled sessions. I will provide parents with a verbal summary of their child's treatment periodically, as requested, and/or when treatment is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or a danger to someone else, in which case parents and/or proper authorities will be notified of my concern. Whenever disclosures are anticipated, I will discuss related matters with the child, if possible, and do my best to handle any objections he/she may have. Please review the additional consent for treatment with a minor.

Professional Records

The laws and standards of my profession require that I keep PHI about you in your Clinical Record for a minimum of six years after the last contact for adults and three years after a minor reaches age 18. Except in unusual circumstances that involve a substantial risk of imminent psychological impairment or imminent serious physical danger to yourself and others, you can have access to a copy of your record, if you request it in writing (copy fees may apply). I will notify you if anything is withheld. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you schedule an appointment to initially review them in my presence and copy what you may need at that time or have them forwarded to another mental health professional so you can discuss the contents.

Professional Fees, Payment Policies, and Terms

My fees range from $225-260 for the initial (diagnostic) session. Psychotherapy fees are $175 per 45-minute individual session and $70-140 for 25-50 minute individual behavioral weight management sessions. In addition to scheduled appointments, I charge a prorated fraction of this fee for other professional services, including but not limited to report-writing, telephone conversations lasting longer than 10 minutes, consultation with other professionals with your consent, and preparation of records or treatment summaries. A $25.00 fee will be charged for any returned check. The client agrees to pay all charges in accordance with the Payment Policy outlined herein. Please be reminded that the process of psychotherapy is different for everyone, and progress is strongly reliant upon the client's active participation and compliance. All payments are non-refundable and due at the time of service. Failure to keep current with appointments and payments may result in an interruption of therapy. Such will be discussed with you in advance of any action being taken. I can use legal means to secure the payment, which may involve running your credit card, hiring a collection agency, or going through small claims court, which may require me to disclose otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

If you become involved in legal proceedings that require my participation, you will be responsible for payment of my professional time, even if I am called to testify by another party. Because of the difficulty of legal

involvement, my fees are doubled per hour for preparation, transportation, and attendance. Should I incur collection charges or legal fees related to your care, you also agree to pay these in full. Please note that I reserve the right to decline client's seeking reports for third party opinions, as well as disability and divorce cases. The practice is focused on treatment and cannot sustain the amounts of additional report writing these cases require.

Health Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. Health insurance policies usually provide some coverage for mental health treatment, though benefits have become increasingly more complex due to the rising costs of health care. I elect NOT to participate with any health insurance plans or policies, and all visits are strictly fee for service. No claim filing or pre-authorization/certification courtesies are available, and you (not your insurance company) are responsible for full payment of my fees. If you elect to file claims independently, I will provide you with a Super Bill/receipt at the time of each visit, providing the appropriate mechanism by which you may file a claim with the appropriate insurance plan.

If you plan to file for insurance reimbursement, you are advised to carefully review the mental health benefits of your insurance policy and to call your plan administrator to assess benefits. Please note that your health insurance company may require that I provide encounter information for any services rendered and claimed against your health care plan. This information generally includes diagnostic impressions, treatment plan, reason for treatment, and prognosis for treatment but may also include a request for additional material, such as the entire patient record. In such situations, I will make every effort to release the minimum information about you that is necessary for the purpose requested. Nevertheless, the released information may become part of the insurance company files and will likely be stored in a computer network. Though insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In fact, records are often forwarded by a client's insurance plan to the ***Medical Information Bureau*** (MIB), at which time the client's health history becomes available to other insurance companies without the client's knowledge or consent. As such, I want clients to be informed that the release of any medical or diagnostic information through the claims filing process may present a potential risk that could be personally damaging to unknowing clients should an inappropriate party have access to the MIB national database. I am happy to provide you with a copy of any report I submit, if you request it.

> ***Medicare Part B Entitlement Policy:*** I gladly treat clients over the age of 65, but I do not participate in the Medicare Part B program. Medicare-eligible clients must sign a Waiver of Medicare Part B Entitlement, indicating that my services will not be claimed against the Medicare Part B Program but are instead the client's financial responsibility. Current laws require that both the client and provider sign this waiver.

Protocol for Secure Storage, Transfer, and Access to Client Records on Termination of the Practice

In the event that I terminate my practice, I will notify active clients by letter and/or direct verbal communication and provide them with a phone number by which they may contact me. For reasons of personal privacy, I will only provide direct access and personal contact information to current or recent (six months) clients. Clients may also contact the Arizona Psychological Association to convey a request for current contact information. I will maintain records for the required period of time, and I will respond to client requests for access to their medical records in a timely manner (i.e., within 30 days or other legally or ethically responsible requirements, unless prohibited by illness or temporary travel unavailability). I will dispose of unclaimed records after the current legal and/or legally specified time requirements by destroying them, so that no confidential information remains in usable form. In the event that circumstances require, I will forward record access and responsibility to another professional who will respond to record requests in accordance with legal and professional standards. Records are currently located at 9590 E. Ironwood square Drive, Suite 210, Scottsdale, AZ 85258.

Client Responsibilities

Each client is responsible for providing accurate contact and billing information. If telephone numbers and/or addresses change, please inform me or my business office.

M. Elicia Nademin, Ph.D.

CONSENT FOR PSYCHOLOGICAL SERVICES

I have read, understand, and accept the provisions of this Agreement and have had any and all questions answered to my satisfaction regarding the policies outlined herein. I agree to abide by all of the terms herein and understand that if I violate any provisions of this agreement, my treatment may be terminated. I also understand that this Agreement is binding in the State of Arizona and that the stated provisions are for my protection and that of Dr. Nademin. I have informed Dr. Nademin of any ongoing or pending legal proceedings I am (or could be) involved in. The original copy of this agreement will become a part of my private medical record.

_____ _____
(Printed Name) *(Date)*

_____ _____
(Signature) *(Date of Birth)*

PAYMENT AGREEMENT

I understand that all payments are due at the time of service. Dr. Nademin will provide me with a "Super Bill," if requested, which is a receipt that functions as a claim that can be submitted to my insurance company for possible reimbursement. I understand that there is a 24-hour cancellation/rescheduling policy and that I will be charged $100 (or $40 if 30-minute behavioral weight management client) if a scheduled appointment is not cancelled with a minimum of 24 hours notice. Finally, I understand that due to scheduling needs of other patients, Dr. Nademin is not able to extend my session time if I arrive late to an appointment and that in such cases, I will be responsible for payment of the full session fee.

_____ _____
(Printed Name) *(Date)*

_____
(Signature)

M. Elicia Nademin, Ph.D.
*3040 E Cactus Rd. * Suite A * Phoenix, AZ 85032*
*(O) 480-221-8816 * (F)* **602-494-3131** * *www.aztherapeutic.com*

CHILD THERAPY CONSENT FOR PSYCHOLOGICAL SERVICES

Prior to beginning treatment, I will review with you terms of the general informed consent policy. Working with children, however, involves unique considerations, so I may remind you of subsequent important issues as they arise in treatment with your child. Therapy with youth involves many benefits but also, at times, involves risks. Your child, you, and I may not always agree regarding the best interests of your child; however, if disagreements occur, I will consider your perspectives thoroughly, and we will work together to resolve disagreements in a way that enables and enhances your child's therapeutic progress. Ultimately, you will decide whether therapy will proceed. If you decide that therapy should be discontinued, I will honor that decision, though I ask that you allow the option of having a 1-3 closing sessions to appropriately end the treatment relationship.

Psychotherapy is most effective when a trusting relationship exists between the clinician and the client. Privacy is crucial in securing and maintaining that trust, and I will be requesting your child's assent prior to beginning services in hopes of enhancing accountability and motivation for treatment. While one goal of treatment is to promote a stronger and improved relationship between children and their parents, doing so often requires that children be allowed a "zone of privacy," whereby they feel free to discuss personal matters with greater freedom. This requires that I ***not*** disclose information about what your child has shared without his/her consent. Please be aware that particularly among adolescents (aged 13-17), for whom greater independence and autonomy are vital, sensitive information regarding sexual contact, alcohol, drug use, and/or other potentially problematic behaviors may be revealed. These behaviors are, at times, within the range of normal adolescent experimentation but at other times may require parental intervention. Prior to treatment onset, we must carefully and directly discuss your feelings and opinions regarding acceptable behavior.

By signing this agreement, you agree to grant your child a level of privacy with the assurance that I will inform you immediately if your child stops attending sessions or if I ever believe your child to be at serious risk of harming him/herself or another. If it is necessary to refer your child to another mental health professional with more specialized skills, I will also share that information with you and assist you with an appropriate referral. At the end of your child's treatment and/or as appropriate during treatment duration, I will share with you verbal summaries of progresses made and areas likely to benefit from future intervention.

Although my responsibility to your child may require involvement in conflicts between you, I would like your agreement that the involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will not only treat anything that is said in session with me as confidential but also that you both agree to refrain from using my involvement with your child as an attempt to gain advantage in any legal proceeding between you and a partner. In particular, this requires your agreement that in any such proceedings, neither of you will ask him/her to testify in court, whether in person or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done. Note that such agreement may not prevent a judge from requiring testimony from me. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information, as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me two times my hourly fee for time spent traveling, preparing reports,

testifying, serving in attendance, and completing any other case-related activities. Such payment will require a retainer, in advance. The clinician will discuss payment arrangements with you, should such a situation arise.

In accordance with State Laws & Rules, all records are retained for a minimum of three years from the date a minor reaches the age of maturity (18) or at least six years after the last date the child received medical or health care services from the provider, whichever occurs later. If you wish to review your child's chart, I am happy to arrange an appointment to review it with you, but I ask for advanced notice to notify your child and to process with him/her this request. If you would like duplicates of your child's chart, please allow me adequate time to copy it. Copy fees will be assessed. Please note that I cannot re-disclose information received from other professionals. If I receive a request for records by someone other than you, such as an attorney or by subpoena, my policy is to initially try to schedule an appointment with you to discuss the situation and to ascertain that you are aware of the request and its implications.

Parent/Guardian (Signature) Date	Parent/Guardian (Printed) Date
Child (Signature) Date	Child (Printed) Date

M. Elicia Nademin, Ph.D.

CONTACT INFORMATION IF CLIENT IS A MINOR

If the client is a minor, please fill out the following:

Mother's Name_____ Home Phone _____

Work Phone _____ Cell / Pager _____

Address _____ City_____State _____Zip_____

Father's Name _____ Home Phone _____

Work Phone _____ Cell / Pager _____

Address _____ City_____State _____Zip_____

***Contact Person in Case of Emergency*: _____**

Relationship_____

Telephone (_____) _____ Other Telephone (_____)_____

Please list names of step-parents or additional guardians, if applicable.

_____

_____

Are the client's biological parents still married? **Y / N**

If no, do the client's parents share legal custody? **Y / N**

Is the client adopted? **Y / N**

If yes, does the client know that he/she is adopted? **Y / N**

ARIZONA NOTICE FORM

Notice of Dr. Nademin's Policies and Practices to Protect the Privacy of Your Health Information

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

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I may *use* or *disclose* your *protected health information* (*PHI*) for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  - *Treatment* involves my provision, coordination or management of your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychiatrist.
  - *Payment* is the reimbursement I receive for providing your healthcare. Examples of payment are my disclosure of your PHI to your health insurer in the interest of obtaining reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my office, such as sharing, releasing, consulting, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations, when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – I am required to report PHI to the appropriate authorities when I have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.
- *Incapacitated Adult and Domestic Abuse* – If I have the responsibility for the care of an incapacitated or vulnerable adult, I am required to disclose PHI when I have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred.
- *Health Oversight Activities* – If the Arizona Board of Psychiatric Examiners is conducting an investigation, then I am required to disclose PHI upon receipt of a subpoena from the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If you communicate to me an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and I believe you have the intent and ability to carry out such a threat, I have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police and in order to initiate hospitalization procedures. If I believe

there is an imminent risk that you will inflict serious harm on yourself, I may disclose information in order to protect you.

- *Worker's Compensation* – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychiatrist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

  The fee is determined pursuant to Arizona Revised Status § 12-351-(F)(1), those charges are as follows:
  1. Ten cents ($0.10) per page of standard reproduction of documents
  2. Actual cost for reproduction of documents requiring special process
  3. Ten dollars ($10.00) per hour per clerical cost.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a notice in person or by U.S. mail. I will require a signature of receipt with an understanding that it is to be returned to my office.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact my office manager at 480.451.3454.

If you are concerned that I have violated your privacy rights and wish to file a complaint with me/my office, you may send your written complaint to me personally or to my office manager at:

9590 E. Ironwood Square Dr. Ste. 210 / Scottsdale, AZ 85258

If you have further concerns, you may also contact the Ethics Committee of the Arizona Psychological Association (AzPA) for more information or send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The AzPA office, named above, can provide you with the appropriate address, upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on August 28, 2009.

North Scottsdale Psychiatric Specialists
M. Elicia Nademin, Ph.D.
9590 E. Ironwood Square Dr., Ste 210
Scottsdale, AZ 85258
(O) 480.451.3454 / (F) 480.451.3453

M. Elicia Nademin, Ph.D.

*9590 E. Ironwood Square Drive * Suite 210 * Scottsdale, AZ 85258*
*(O) 480.451.3454 * (F) 480.451.3453 * www.shrinkinfo.com*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PSYCHOLOGIST'S POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

I, _____ acknowledge that I have received a copy of Dr. M. Elicia Nademin's Notice of Privacy Practices. This Notice describes how Dr. Nademin may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

_____ _____
Signature of client or representative Date

_____ _____
Printed name of client Date

_____
Relationship to patient