

2025 office policies and privacy practices

UPDATED 2025-Office Policies

I appreciate the opportunity to work with you and your family. The following information describes some important policy and procedural matters concerning my practice. Please read this material and sign the acknowledgement. If you have any questions, feel free to discuss them with me.

CONSENT TO TREAT

The undersigned patient or responsible party (parent, legal guardian, or conservator with legal authority to make medical and mental health care decisions for the patient below) consents to, and authorizes services, provided by Jillianne Grayson, MD. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures, and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment modalities.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

TREATMENT PLAN

The patient's first two visits are solely for evaluation and to determine whether Dr. Jillianne Grayson can provide appropriate services. The individual treatment plan establishes an ongoing working relationship between a patient and Dr. Grayson. **Adherence to your individual treatment plan is required** to remain a patient in Dr. Grayson's practice. Your treatment plan includes a required frequency of patient visits to the office to be seen by Dr. Grayson. **You are required to be seen every 6 months to stay an active patient of Grayson Psychiatry (if you are on controlled substances you are required to be seen every 3-4 months).**

If for some reason treatment is not going well, I might suggest you see another professional for an evaluation. If you wish for another professional's opinion at any time, I will help you find a qualified person and will provide him or her with the information needed. If you wish to stop treatment at any time, I ask that you agree to meet for at least one more session to review your treatment and transfer to a new provider to make it as smooth as possible.

CONTROLLED SUBSTANCES

Controlled substances/ medications such as benzodiazepines (Klonopin, Xanax, Valium, Ativan ect.) sleep aids and stimulants (Adderall, Ritalin ect.) are sometimes used in the treatment of psychiatric disorders. It is important that you understand the risks and benefits of using these medications before you receive them from your outpatient providers. Because these medications can be addictive, develop a tolerance and can have health consequences we have set up guidelines to protect against these dangers.

1. Be clear with this doctor if you or a family member has ever had a history of addiction or drug or alcohol abuse.
2. Be clear with this doctor of all the other medications that you are currently taking including narcotic pain medication, methadone, suboxone ect.
3. Be clear with this doctor if you are currently using alcohol, cannabis/ TCH or other drugs.
4. Once you receive a controlled substance you are responsible for this prescription and medication. Controlled substance may not be taken more often than prescribed nor be taken or distributed to an unauthorized person as this is a Federal Offense.
5. Early refills will not be offered in response to misuse, overuse or for convenience. Lost or stolen prescriptions will not be replaced, and the clinic will not authorized early refills in these instances.
6. If it is determined that you are using a controlled substance inappropriately, that agent will be tapered and not prescribed again. Including if it is determined that a parent/guardian is using a controlled substance that is prescribed to the child/patient.
7. If you have occurrence/ episode into overuse of alcohol or drug use, the controlled substance will be tapered and not prescribed again.
8. If it is determined that there is a medication interaction that could be life threatening, the controlled substance will be tapered to stop.
9. If there are medical compromise/ significant physical safety concerns with use of this agent, the controlled substance will be tapered to stop.
10. The eventual goal with most controlled stances is to taper off them eventually-- controlled substances are usually not for long-term use. However, abrupt discontinuation of some controlled substances could result in seizures, withdrawal or even death.
11. Using controlled substances with alcohol, marijuana or other illegal drugs is a sign of addiction. If you are found to do this, you will be tapered of this agent and advised to seek substance abuse treatment immediately.

12. Coordinated care will be required for controlled substance prescribing. This doctor is consistently evaluating your medication and condition for dangerousness. A release of information to your other providers/ doctors will likely be obtained to ensure your safety. Failure to agree to this may result in delay in prescribing and/or stopping these high risk agents.

13. Monitoring of the DEA Controlled Substance Registry and communication with your pharmacy will be used to verify your history of filling prescriptions.

14. Agreeing to any lab request or drug screen is necessary. Refusal or inability to provide drug screen at random will be assumed that it contains unauthorized drugs.

15. **You must keep your appointments to obtain refills on your medication. Controlled substances are typically NOT refilled or altered outside your appointments. In general, if you receive a controlled substance, you will be expected to be seen at least every 3-4 months, often in person (at least once a year). Failure to keep appointments may result in discontinuation of these high-risk medications.**

16. Remember these guidelines are designed to help reduce the risk associated with taking controlled substances. Breach of this agreement may result in the discontinuation of these agents. In rare instances, breach of this agreement may result in dismissal from this clinic.

USE OF MIND-ALTERING SUBSTANCES

Please do not present for appointments under the influence of any mind-altering drugs and/or alcohol. Should a patient present for treatment under the influence of mind-altering drugs and/or alcohol, the appointment will be canceled, and the patient will be charged for the full appointment.

DISCLOSURES AND CONFIDENTIALITY

Each patient is required to complete and sign all patient forms to the best of their knowledge. If the patient has a Legal Guardian and/or is subject to a child custody agreement, then a copy of the most current applicable document(s) will be provided to Dr. Grayson. All communication between physician and patient is held in the strictest confidence unless:

1. the patient authorizes release of information with a signature.
2. You may access your records upon request. In some very rare situations, I may temporarily remove parts of your records before you see them. This would happen if I believed that the information would be harmful to you, but I will discuss this with you. For minors, legal guardians also hold a right to access these files.
3. the physician is ordered by a court to release information.
4. child or elder abuse/neglect is suspected.
5. Dr. Grayson becomes concerned for the patient's safety or the safety of others.
6. In the case of 3 or 4, Dr. Grayson is required by law to inform authorities and/or potential victim.

CONSENT TO BE MONITORED AND RECORDED FOR SECURITY PURPOSES

Please note that Grayson Psychiatry has implemented closed-circuit video surveillance in the waiting areas, hallways, and front door for security purposes. This has been put in place for the security of providers and patients. There is no audio/-visual recording in treatment rooms. By signing you are agreeing to being the subject of closed-circuit video surveillance at Grayson Psychiatry and to being recorded and taped because of this.

FEES AND INSURANCE

Dr. Grayson does not participate in any insurance plans. Patients with private insurance may file claims for reimbursement with their insurance companies for out-of-network service; Dr. Grayson will provide patients with information to allow them to do so but the claims must be submitted by patients directly to the insurance company. Payment is due at the time of service. **To ensure that Dr. Grayson is paid for services rendered in a timely manner, payment is made at time of making appointment (unless otherwise agreed upon). Dr. Grayson uses Stripe and Square for credit card processing. Credit card is preferred method of payment.**

You are responsible for timely payment of Dr. Grayson's services, regardless of the status of any reimbursement you may seek elsewhere. If your credit card is declined for any reason, and your **balance is not paid within 5 business days, then your patient account will incur a \$50 late fee (and an additional \$50 for every additional week)**. Dr. Grayson may impose reasonable interest, late charges, direct collection costs, court costs, and/or reasonable attorney's fees should your patient account become delinquent. For returned checks, the Patient will be charged for the amount of the returned check plus a \$50 fee. Any other financial arrangement must be made with Dr. Grayson, in writing, prior to service.

Dr. Grayson has opted-out of providing services to Medicare beneficiaries and does not provide services to a Medicare beneficiary without a current Medicare private contract. Additionally, Dr. Grayson does not provide services to an HMO beneficiary without an HMO private contract in place.

Current Fees:

- 25 min follow up- \$265
- 50 min follow up- \$365
- 2 appointment Intake- \$895 and \$395
- 60 min therapy session- \$350

• **Physician Services for established patients, 15 minutes \$90**
(this includes paperwork, clinical phone calls, prior authorizations, extensive care coordination, urgent prescription requests, etc.)

LEGAL SERVICES

Rarely, but on occasion, a court will order a provider to testify, be deposed, or appear in court for a matter relating to your treatment or case. To protect your confidentiality, I strongly suggest not being involved with the court. If I am subpoenaed, your private mental health records are also at risk of being subpoenaed. All services related to a legal case, a subpoena, a court case, and/or litigation will be billed in 15-minute increments at a rate of three times my hourly rate \$1,095 per hour. If I get called into court by you, your attorney, or an attorney representing your child, you will be charged the hourly rate, including any time involved with the court case (including but not limited to, travel time, meals, consultations with lawyers representing any involved party including my own lawyer, emails, affidavits, correspondence of any kind, phone calls, depositions, attendance at courtroom proceedings and any wait time prior to or in lieu of actual court appearance.) You will be billed for any legal fee I incur because of my involvement. All the charges above may be billed directly to the credit card on file.

COMMUNICATION POLICY

Patients have the option of participating in Spruce a HIPAA-compliant third-party vendor, for the purpose of communicating clinical information, scheduling, billing and medication refills. This is the best way to reach Dr. Grayson. Due to privacy concerns, any electronic communication (such as email, texting, Facebook, Skype, etc.) containing clinical information will not be read, and will be deleted without response. **Email is not HIPAA-compliant and therefore should be reserved for logistical issues only. If you opt out of using Spruce, please use the telephone to communicate patient information with Dr. Grayson.**

• **NON-URGENT CLINICAL QUESTIONS BETWEEN VISITS**

- o **Please send a message via Spruce;** or leave a message on Dr. Grayson's voicemail. You will receive a call back or response as soon as possible, usually by the next business day.
- o **Dr. Grayson does not regularly review her emails, please do not use email as a means of communication with Dr. Grayson.**
- o Dr. Grayson's voicemails and Spruce are not reviewed on Fridays, weekends, Federal holidays, or after 5pm on Monday-Thursday. For emergency and urgent situations, please see "Urgent/Emergent Situations."

• **URGENT/EMERGENT SITUATIONS-**

- o **If you are experiencing a medical or psychiatric emergency, please call 911 or go to the nearest emergency room.**
- o If you need to reach Dr. Grayson or the covering physician urgently, then call Dr. Grayson's office phone number, and listen to the complete outgoing message. If another physician is covering for her, the outgoing message will have instructions for how to contact that person. You may also use the Urgent button on Spruce.

• **PHARMACY REQUESTS-**

- o **Medication refills should be requested during appointment times.**
- o **It is the Patient's/Parent's responsibility to request medication refills in a timely manner. If refills are needed in between appointments, please submit requests via Spruce.**
- o **Dr. Grayson's office requires at least 3 (three) business days in advance to respond to prescription refill requests.**
- o **Urgent prescription requests requiring a response in less than 3 business days' notice may be subject to a fee (\$90).**
- o **Prescription refill requests can only be provided to current patients of the practice.**
- o **Patients must request refills; no auto requests are considered from anywhere anytime, including automated pharmacy requests.**

• **APPOINTMENT REMINDERS-**

Patients have the option of receiving appointment reminders via text and email. These reminders are automatically generated by HIPAA-compliant third party vendor Dr.Chrono(onpaitent) and Calendly. Responses to these emails and texts are not received or read by Dr. Grayson.

• **PHONE-**

I consent to receive calls from Dr. Jillianne Grayson for my protected healthcare and other services at the phone number(s) listed in the portal, including my cell phone number provided. I understand I may be charged for such calls by my cellular carrier and that such calls may be generated by an automated dialing system. I understand that I can revoke this consent at any time.

CANCELLATIONS OR MISSED APPOINTMENTS

If you are unable to make an appointment, please let Dr. Grayson know as soon as possible by calling the office and leaving a voicemail message or canceling online.

- **Because your appointment time is reserved for you, you will be charged the full fee for the scheduled service(s) unless you cancel 24 hours in advance (not including weekends or holidays).**
- Exceptions to the missed appointment fee will be made for weather emergencies.
- If you are late for your appointment, you will be seen for the remaining appointment time and will be charged the full appointment fee. If you arrive for your scheduled appointment with 15 minutes or less remaining in their scheduled timeslot, you will not be seen and be charged the full appointment fee.
- Excessively late arrivals are treated the same as a No Show or Late Cancellation. Arriving with less than 15 minutes does not allow Dr. Grayson adequate time to assess patient needs without affecting others' appointments.
- **After 3 no shows, Dr. Grayson reserves the right to terminate services.**

TELEMEDICINE

Telemedicine/teletherapy involves the use of synchronous electronic communications to enable clinicians and patients-/clients to work together remotely. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. There are potential risks associated with the use of telemedicine/teletherapy. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

Emergency Situations:

If a situation occurs where we are talking and get disconnected and you are in crisis, you agree to call 911, go to your local emergency room immediately or contact the National Suicide Hotline at 800-784-2433. If I have concerns about your safety at any time during a phone session, I will need to break confidentiality and call 911 (if located in the same county or emergency services in the area you are located at the time of the call) and/or your emergency contact immediately. Please note that everything in the informed consent that you have signed, including all the confidentiality exceptions, still applies during phone/video sessions.

TERMINATION

After appropriate attempts to contact the Patient, if Dr. Grayson determines that **treatment is not being effectively used or payment is in default, Dr. Grayson may terminate treatment** and provide a list of other qualified practitioners.

Should the Patient fail to adhere to the terms of the individual treatment plan, unless other arrangements have been made in advance, for legal and ethical reasons, they must consider the professional relationship discontinued.

If you wish to stop treatment at any time, I ask that you agree to meet for at least one more session to review your treatment and transfer to a new provider to make it as smooth as possible.

CHANGES IN OFFICE POLICIES

Professional fees and/or office policies may change from time to time. Dr. Grayson will make every effort to inform you in advance of changes in professional fees and/or office policies. Generally professional fee adjustments occur annually on January 1st.

Acknowledgement of Receipt of Office Policies

I have read Dr. Grayson's Office Policies. My signature below indicates that I both understand and agree to these Policies. The undersigned patient or responsible party (parent, legal guardian, or conservator with legal authority to make medical and mental health care decisions for the patient below) consents to, and authorizes services, provided by Jillianne Grayson, MD. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures, and other appropriate alternative therapies.

Patient First Name

Patient Last Name

Patient DOB

Parent/Legal Guardian First Name (if applicable)

Parent/Legal Guardian Last Name (if applicable)

Signature of Adult Patient or Parent/Legal Guardian

Date

Today's Date

NOTICE OF PRIVACY PRACTICES OF GRAYSON PSYCHIATRY

Grayson Psychiatry must collect timely and accurate health information about you and make that information available to members of your health care team in this agency, so that they can accurately diagnose your condition and provide the care you need. There may also be times when your health information will be sent to service providers outside this agency for services that this agency cannot provide. It is the legal duty of *Grayson Psychiatry* to protect your health information from unauthorized use or disclosure while providing health care, obtaining payment for that health care, and for other services relating to your health care.

The purpose of this *Notice of Privacy Practices* is to inform you about how your health information may be used within *Grayson Psychiatry*, as well as reasons why your health information could be sent to other service providers outside of this agency.

This *Notice* describes your rights in regards to the protection of your health information and how you may exercise those rights. This *Notice* also gives you the names of contacts should you have questions or comments about the policies and procedures *Grayson Psychiatry* uses to protect the privacy of your health information.

Please review this document carefully and ask for clarification if you do not understand any portion of it.

Patient Acknowledgement

I have received *Grayson Psychiatry's Notice of Privacy Practices*, which describes this agency's methods for protecting the privacy of my health information that is used in providing health care services to me.

Patient (or Personal Representative)

Date

Today's Date

Notice of Privacy Practices

Jillianne Grayson, MD 107 Commerce Center Drive Unit 201, Huntersville, NC 28078

This practice's Privacy Officer can be reached by leaving a message at (980) 202-2490

Effective Date: November 1, 2021; Updated January 1, 2025

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you and to enable us to meet our professional and legal obligations to operate this medical practice properly.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer and in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical

practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we may give your pharmacy and/or health plan the information it requires before it will cover your prescription.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services, referrals, and/or prescriptions. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.
4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. **Law Enforcement.** We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. **Coroners.** We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. **Organ or Tissue Donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. **Public Safety.** We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. **Proof of Immunization.** We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
18. **Specialized Government Functions.** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. **Workers' Compensation.** We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. **Change of Ownership.** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. **Breach Notification.** In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.
22. **Psychotherapy Notes.** We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. **Right to Request Special Privacy Protections.** You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. **Right to Request Confidential Communications.** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. **Right to Amend or Supplement.** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your

disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. **Right to an Accounting of Disclosures.** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. **Right to a Paper or Electronic Copy of this Notice.** You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. All complaints should be submitted in writing. If you file a complaint, we will not take any action against you or change our treatment of you, in any way. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

The North Carolina Department of Health and Human Services operates an information and referral service located in the Office of Citizen Services, known as CARE-LINE, which has been designated to receive and document complaints and concerns regarding DHHS privacy practices, policies, and procedures related to the protection of individually identifiable health information. Contact information is as follows:

CARE-LINE

2012 Mail Service Center
Raleigh, NC 27699-2012

Voice Phone (English and Spanish):

1-800-662-7030 (Toll Free)

(919) 733-4261 (Triangle Area and Out of State)

FAX: (919) 715-8174

TTY: 1-877-452-2514 (TTY Dedicated)

(919) 733-4851 (TTY Dedicated for local or out of state calls)

Email: care.line@ncmail.net

You may also send a written complaint to the United States Secretary of the Department of Health and Human Services.

Contact information is as follows:

Office for Civil Rights

U.S. Department of Health and Human Services

Atlanta Federal Center, Suite 3B70

61 Forsyth Street, S.W.

Atlanta, GA 30303-8909

Voice Phone (404) 562-7886

FAX (404) 562-7881

TDD (404) 331-2867