Emily Fogle, Psy.D.

275 Collier Road, Ste 100-A
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(770) 376-7764
emilyfogle@gmail.com

EGG DONOR SCREENING QUESTIONNAIRE-REVISED (EDSQ-R)

Name_____ Date_____

Phone Number (Cell or home) _____ Age _____

Height_____ Weight_____ Eye Color_____ Hair Color_____

The purpose of this questionnaire and the clinical interview that follows is to help you understand as fully as possible the meaning and long-term implications of your decision to donate your eggs to an individual or couple. It is also designed to be sure that you are emotionally and psychological prepared to do this. Please answer honestly and completely and jot down any questions that you might have and bring them to the interview. Thank you.

SELF REPORT

Please describe yourself.

What sports, hobbies or special interests do you have?

What are some things that make you happy or satisfied?

What kinds of people do you like the most? The least?

Describe a situation where you had to work hard to achieve a goal. How did you do it?

What are your religious affiliations, if any?

What is your family's ethnic heritage? List all of them.

LIFE STRESS AND COPING SKILLS

What kinds of stress do you encounter in your current life?

What strategies do you use to manage your stress?

How do you deal with criticism?

Describe your support system (friends, family, religious or volunteer community, etc)

Describe any significant losses regarding people or events in your life.

What happened and at what age did this occur?

How did you feel at the time? How do you feel about it now?

Please describe any health problems you have had in your life.

FAMILY BACKGROUND

Where were you born? Where were you raised?

Who raised you?

List your siblings, ages, and your relationships with them.

What positive experiences did you have as a child?

What negative experiences did you have as a child?

Did you experience any physical, sexual or emotional abuse as a child or young adult? YES or NO

Have you experienced any significant losses in your life?
If YES… What were they and when did you experience them?

OTHER RELATIONSHIPS

Are you currently married, engaged or in a serious relationship?

Describe your relationship with your spouse/partner (e.g. happy, strained).

How do you and your spouse/partner deal with conflict and adversity?

Has your spouse/partner experienced any significant losses?
If YES, please describe.

Have you been previously married?
If YES, please list the dates of the marriage and termination of that marriage.

How did the loss of this marriage affect you?

Please describe your current significant friendships.

WORK AND EDUCATION

What college(s) have you attended?

When did you graduate?

What was your major?

What is your most recent grade point average?

List your degree(s), if any.

What do (did) you enjoy about school?

What kind of work do you do?

How long have you been at your current employer?

How long have you been in your current position?

What are your long-term career interests or goals?

FINANCIAL STATUS

Are you … (Circle all that apply)
Financially comfortable? On a tight budget?
Significantly in debt? Repaying student loans?

Do you have any credit card debt?
If so, how much?

How well do you manage your money?

What will you do with the money you receive from donating eggs?

LEGAL ISSUES

Describe any circumstances on which you have had legal issues or contact with the law.

Have you ever been sued? Y or N Sued another party? Y or N Consulted an attorney? Y or N
If YES, please describe.

MEDICAL HISTORY

Do you have any significant medical problems? If YES…please describe.

Do you take any medications?
If YES, list the medication(s) and reason for taking them?

Do you have any allergies?
If YES, to what?

Do you have any tattoos or body piercings?
If YES, how many and when did you get them?

ALCOHOL AND DRUG HISTORY

Have you ever smoked cigarettes?
If YES…
At what age did you begin to smoke?

At what age did you quit?

Do you currently smoke?

How many packs of cigarettes do you currently smoke per day?

Have you ever used recreational drugs?
If YES…
Which drugs have you used?

Do you currently use any of these drugs? Which ones? How often?

Do you ever drink alcoholic beverages?
If YES…
How often do you drink?

How much do you drink in one evening?

How old were you when you first tried alcohol?

Have you ever experienced a Blackout?

Have you ever been arrested for DUI?

Have you ever experienced DTs?

Do you have any family members who have been alcohol- or drug-addicted?
If YES… Who?

REPRODUCTIVE EXPERIENCE AND SEXUAL HISTORY

Have you ever been pregnant?

If YES… How many times?

What was your relationship with the father(s)?

Were there any pregnancy health related issues?

What was the outcome of each pregnancy (e.g miscarriage, abortion)?

What were your feelings about each pregnancy?

Do you want to have children in the future?

Do you and/or your spouse/partner have any children?
If YES…describe your relationship with the children.

Have you ever had any infertility problems?

Has anyone in your family had any infertility problems?

PSYCHOLOGICAL HISTORY

Have you ever experienced a depression?

Have you ever had anxiety attacks?

Have you ever had an eating disorder?

Have you ever seen a psychologist, counselor, psychiatrist or therapist? If YES… When?

For how long?

For what reason?

What did you learn from your experience?

Have you ever taken psychiatric medications?

If YES…Please list

Have you ever been hospitalized for emotional problems?

Does anyone in your family have any mental or emotional issues?

UNDERSTANDING OF DONOR EGG PROCEDURES AND RESPONSIBILITIES

How did you learn about egg donation?

Are you comfortable with the information given to you by the fertility center?

Have you ever been an egg donor before?
If YES… What was your experience like?

Do you know someone who has been an egg donor?
If YES… What was her experience like?

Why do you want to be an egg donor?

Are the following people supportive of your becoming an egg donor?

Parents? YES or NO or HAVE NOT BEEN TOLD

Spouse/Partner? YES or NO or HAS NOT BEEN TOLD

Friends YES or NO or HAVE NOT BEEN TOLD

Is anyone "strongly encouraging" you to become an egg donor?

If YES, is this causing you any confusion or discomfort?

Describe your work or school schedule. Do you have flexibility?

What are the procedures, drugs, schedules and timelines involved in being a donor?

Who will be with you during the egg extraction?

What is your understanding of the risk to your future fertility as a result of the egg donor process?

Would you be willing to go ahead with the procedure if the risk were significant?

Describe any concerns or fears you may have regarding egg donation.

Are you morally comfortable with abortion?
If YES… Under what circumstances?

Are you morally comfortable with selective reductions (medically aborting one or more embryos for medical or health-related reasons)?
If YES… Under what circumstances?

Do you know what will happen to any of your fertilized eggs that are ultimately unused?

How do you feel about NOT being told whether a child is born from your eggs?

How do you feel about NOT knowing any information about the couple who receives your eggs?

How do you feel about the couple who receives your eggs NOT knowing who you are?

Write down any questions or concerns you have about moral, ethical or legal issues related to the egg donor procedure.

Write down any questions or concerns you have about emotional issues related to being an egg donor.

Write down anything else you would like to share about yourself.

Write down any other questions you would like to discuss in our meeting.

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DISCLOSURE INFORMATION & PSYCHOLOGICAL SERVICES AGREEMENT FOR EGG DONOR AND SURROGACY CANDIDATES

Thank you for your interest in becoming an egg donor or surrogate. The gift of a child is very precious for couples who are struggling with infertility challenges. This document (agreement) contains important information regarding psychological evaluation and consultation services that will help establish suitable egg donor and surrogacy candidacy. This document includes client rights throughout this process, as well as outlines business policies and expectations for services rendered through my practice. Please read this document carefully before we meet in person. We can discuss any questions that might arise about the following policies and procedures at that time. Please be aware that when you sign this document, it will represent an agreement between us.

Service Provider:
Emily Fogle, Psy.D.
Psychologist
Georgia License # PSY003765

Education/Degrees:
Doctor of Psychology (Psy.D.) in Clinical Psychology - University of Denver, 2012
Master of Arts (M.A.) in Clinical Psychology - University of Denver, 2009
Bachelor of Science (B.S.) in Psychology - University of Georgia, 2005

Client Rights and Ethical Conduct in the Practice of Psychology:
The practice of licensed or registered persons in the field of psychology is regulated by the Georgia Board of Examiners of Psychologists. The Georgia Board of Examiners of Psychologists can be reached at 237 Coliseum Drive, Macon, Georgia 31217-3858, (478) 207-2440.

You are entitled to receive information about the methods of psychological evaluation/consultation, the techniques used, the duration of the evaluation/consultation, and the fee structure. Please ask if you would like to receive this information.

You can seek a second opinion from another provider or terminate the evaluation/consultation at any time.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

Confidentiality between psychologist and client is guaranteed by Georgia law except under certain circumstances. For example, psychologists are required to report suspected child abuse, elder abuse, and homicidal or suicidal threats or intentions.

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice of my Privacy Policies and Practices. Please read and sign the included HIPAA notice that lists these rights in greater detail.

Meeting(s) and Procedures:
In general, the process of psychological evaluation entails a variety of techniques for determining and documenting an individual's psychological make-up and yielding findings which may qualify or disqualify individuals from certain practices and procedures (e.g., egg donation or surrogacy). These techniques typically include clinical interviewing, mental status examinations, psycho-diagnostic testing, review of relevant records, and consultation with other professionals.

We will be meeting for a clinical interview during which we will discuss many things about you. After the clinical interview, you may be given a psychological test. Please allot 2 ½ hours for this process. I may also request to review relevant supporting documents or talk with other professionals about you. Following our meeting I will prepare a report summarizing relevant findings.

These procedures are designed to help ascertain whether you will make a good donor or surrogate candidate. A key goal is to help you understand the process that you will undergo and to ensure that being a donor or surrogate will be a positive and healthy experience for you. The information obtained from my assessment will give potential couples the chance to know more about you. When couples choose a donor or surrogate, they often choose someone whom they feel connected to in some special way. My report will help them know more about you as a person. Your history, goals, struggles, interests, talents, humor, relationships and other unique characteristics are the kinds of things with which couples can identify.

It is important to understand that the aforementioned services may change due to circumstances that may arise during the course of your evaluation and/or consultation. By signing this agreement you also understand and agree that:

1) Not every person who wishes to be a surrogate or a donor is an appropriate candidate. For any number of reasons, you might not be approved to participate in a third-party reproductive agreement. In the likelihood you are not approved you release me from any liability related to my opinion and findings of my evaluation.
2) Additional counseling may or may not be required or provided to grant you eligibility as a donor or surrogate following the completion of your consultation/evaluation. You agree that if you are asked to participate in additional counseling you will do so.
3) There may be psychological risks associated with your participation as an egg donor or surrogate which cannot always be accurately predicted. Choosing to participate as an egg donor or surrogate is a decision with lifelong consequences and questions and/or concerns may arise in the future. You understand that you may wish to consult a mental health professional now or in the future regarding any emotional issues that may occur from your participation in this evaluation.
4) Provided I have acted reasonably and with the pertinent professional standards and guidelines, you release me from claims of liability related to any psychological harm that you may suffer as a result of your participation in counseling or evaluation as a prospective donor or surrogate, and accept the risks of psychological harm.
5) This evaluation is not intended to address the legal, ethical, or religious ramifications of becoming an egg donor or surrogate. Should you need further information concerning these issues you should obtain appropriate legal or religious counsel.
6) I may be retained as the evaluator/consultant for the intended parent(s) and these parties may also agree to pay for the evaluation and/or consultation you receive. Regardless, you understand that I maintain a professional responsibility to each client individually and separate from the interests of the other party. You understand that I may advise against the participation of the intended parents, or render other advice that will impact the proposed treatment. Provided I have acted reasonably with my own professional standards and guidelines and any applicable laws governing the practice, you release me from liability with regard to claims of conflict of interest. If you believe this scope or representation is unacceptable, you may request evaluation or consultation from another provider who is qualified. You maintain an independent right to pursue a claim of negligence or malpractice, notwithstanding the above.

By agreeing to complete the donor or surrogacy evaluation, you are also agreeing to allow me to review any assessment material and provide a written report to the appropriate staff at

_____. They may share any or all parts of the report with potential recipient couples. However, only appropriate and qualified staff will have access to your name and any other information about you that might identify you. Any couples reading the report will not know your name. You will not have access to the findings or my report. Please feel free to ask me to clarify any information regarding this process. All questions are good ones.

Contacting Me:
Due to my work schedule, I am often not immediately available by telephone. While I am typically working between 9am and 5pm, I will not usually answer the phone when I am meeting with a client. My telephone is answered by a confidential voicemail system that alerts me to all calls. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please leave a message with the best times when you will be available. If I am unavailable for an extended time, I will provide you with the name of a trusted colleague whom you can contact, if necessary. If you cannot reach me, and you feel that you cannot wait for me to return your call, you should call you family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call.

Should we agree to terminate services at any point during the consultation and/or evaluation services, I will no longer be responsible for responding to any clinical emergencies, unless we have mutually agreed to re-engage in consultation. I am not responsible for any emergencies after the termination of your consultation and/or evaluation. The state of Georgia requires me to maintain records for seven years following the completion or termination of services, at which time these records will be destroyed in a manner that protects your confidentiality.

Communication and Confidentiality:
Please note that cellular telephone and e-mail communications are vulnerable to breeches of confidentiality due to their modes of information transmission. I do communicate with patients via email and cellular telephone. Your preference noted and signature at the end of this document indicates permission and understanding of the following communication methods used in this therapeutic relationship:

Email communications: ____ ____
YES NO

Address preferred:_____

Phone communications: ____ ____
YES NO

Number preferred:_____

Confidentiality:
The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your treatment to others after you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require that you provide written, advance consent. Your signature on this agreement provides consent for those activities, as follows:

- If a client threatens to harm herself/himself, I may be obligated to seek hospitalization or her/him or to contact family members or other parties who can ensure safety.
- I may occasionally find it helpful to consult with other health and mental health professionals about a case. In these consultations, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel it is important to our work together. I will document all consultations in your Clinical Record.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without your consent or obtaining previous Authorization:

- If you are involved in a court proceeding and a request is made for information concerning my professional services (e.g., subpoena or subpoena duces tecum), such information is protected by the psychologist-client privilege law. You have the right to file a motion with the court to quash any subpoena. I will not provide any information to your counsel or other legal party without your written authorization; however, if a court order is issued to me, I have to release the information requested by that order. I will make an effort to notify you in that case, but your authorization is not required. If you are involved in or contemplating litigation, you should always consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally required to take actions when I believe that they are necessary to protect others from harm. In these situations, I may have to reveal some information about a client's treatment:

- If I have reasonable cause to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to believe an elder person or a disabled adult has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report to an agency designated by the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
- If I determine that a client presents a serious danger of violence to themselves or another person, or they are gravely disabled to the extent they no longer provider for their own well-being and safety, I may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client.

If such a situation arises, I will make every effort to fully discuss these circumstances with you before taking any action and I will limit my disclosures to third parties only to the effect necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important we discuss any questions or concerns that you may have now or in the future. The laws governing these issues are quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Additional Information
Dr. Emily Fogle is practicing as an independent practitioner. Please be aware that other than using office space at Atlanta Women's Healthcare Specialists, there is no other business relationship between Dr. Fogle and other treatment providers in the office suite. Dr. Fogle and Atlanta Women's Healthcare Specialists bill separately. Even though physical space is shared, there is not shared liability across providers. Other providers will not have access to your information without your signed release of information.

Client's Statement of Understanding and Agreement

I, _____, agree to participate in all procedures in the egg donor or surrogate assessment in an honest and thorough fashion. I understand that the findings and the report will be sent directly to the appropriate staff at the Atlanta Center for Reproductive Medicine. I waive all rights to the material.

Your signature below indicates that you have read this agreement, agree to its terms, and understand your rights as a client.

By this signature, you also hereby acknowledge that you have received a copy of the HIPAA "Notice of Privacy Practices."

_____
Print Client's name

_____ _____
Client's Signature Date

_____ _____
Emily Fogle, Psy.D. Date

Emily Fogle, Psy.D.

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AUTHORIZATION TO RELEASE INFORMATION

Pursuant to 45 CFR 164.508 and the Health Insurance Portability and Accountability Act,

I, _____, hereby authorize Emily Fogle, Psy.D. to **exchange** relevant information about treatment or the protected health information (PHI) with the following parties. This information includes written and verbal transfer of history, as well as mental health diagnosis and treatment information for the purposes of consultation and coordination with relevant professionals.

This information should only be released to my physician _____, his or her nurse(s), and appropriate staff.

This authorization shall remain in effect until I am no longer a patient of _____ or until such time as I revoke this authorization.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Dr. Fogle generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date

_____ _____

_____ _____
Emily Fogle, Psy.D. Date

I am **revoking** consent and authorization to request or release information.

_____ _____ _____
Signature Printed Name Date

Emily Fogle, Psy.D.

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GEORGIA NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL 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 is when I provide, coordinate or manage 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 psychologist.

– Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain 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, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

• "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], 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 (already released the information according to the 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 – If I have reasonable cause to know or suspect that a child has been subjected to abuse or neglect, I must immediately report this to the appropriate authorities.

• Adult and Domestic Abuse – If I have reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited and is at imminent risk of mistreatment, self-neglect, or financial exploitation, then I must report this belief to the appropriate authorities.

• Health Oversight Activities – If I am the subject of an inquiry by the Georgia Board of Psychological Examiners, I may be required to disclose PHI regarding you in proceedings before the Board.

• Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privileged 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 I determine, or pursuant to the standards of my profession should determine, that you present an imminent and serious danger to yourself or someone else, I may disclose such information in order to provide protection against such danger for you or any other intended victim.

• 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 provided benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist'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 regarding you. 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 the notice from me upon request, even if you have agreed to receive the notice electronically.

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 notify you by mail or in person. Additionally, a requested revised notice of policies and procedures can be sent to the requester by mail.

V. Questions or 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 me (Emily Fogle, Psy.D.) directly at (770) 376-7764.

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to me (Emily Fogle, Psy.D.), at 275 Collier Road, Suite 100-A, Atlanta, GA 30309. You may also send a written complaint to the Secretary of the Department of Health and Human Services, at 200 Independence Avenue S.W., Washington, D.C. 20201.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

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

This notice will go into effect on January 29, 2014.

I reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that I maintain. If you are an active client, I will provide you with a revised notice at your next session following the revision.