Rachel Wolfield, LCSW-R

499 Glen Street, Glens Falls, NY 12801 Phone: 518-798-9187/ Fax: 518-223-0567

Please complete this packet and bring it with you to your first session

Today's date _____/_____/_____

Child's Full Name ____ DOB_____/_____/_____ Age______

Address ____

Parent/Guardian Name(s) ____

Parent/Guardian Address (if different than child's) ____

Parent/Guardian Phone (Home) _____-_____-______ (Cell)_____-_____-______ (Work) _____-_____-______

Parent/Guardian Employer ____________________________ Employer Address ______________________________

Referred by (if any) ____

Emergency Contact Information

In case of emergency, who should be contacted?

Name ____ Relationship___________________________________

Address ____ Phone ____-____-_____ Alternate ____-____-_____

Insurance Information – not required if self-pay

Primary Insurance _______________________________ Subscriber ID________________________________

Subscriber Name ________________________________ Employer ___________________________________

Subscriber DOB _________________________________ Group #_____________________________________

Co-pay amount $ ________________________________ Has your deductible been met? _______________

Personal History

Briefly describe the reason(s) you are seeking help for the child or for your family.

____
____
____
____
____

What is the approximate length of time the child/family has been experiencing this difficulty?

____

What has been the impact of this difficulty on your day to day life?

____

Has the child been in therapy or counseling previously? ____________

If Yes, please provide name(s) of practitioner(s) and approximate dates of treatment.

Practitioner's Name	Dates in treatment	Reason treatment ended

Medical/Mental Health Information

Pediatrician _______________________________ Address____

Phone ____-____-____ Current medical/mental health conditions____

Allergies ____

Is your child on any medications (Prescription and/or Non-Prescription)? _________________ If yes, list below:

Medication	Dosage	Prescriber
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________

Has your child ever experienced any form of abuse or trauma (i.e. physical abuse, emotional abuse, sexual abuse, natural disaster, car accident, etc.)? __________ If yes, please describe below:

____
____
____

Is there a family history of any mental health issues or substance use (i.e. anxiety, depression, addiction)? ________
If yes, please specify below:

____
____
____

Family Composition

Who is currently residing in your home? (Please include everyone living in the home-related and unrelated)

Name_______________________________ Relationship______________________ Age_____

Name_______________________________ Relationship______________________ Age_____

Name_______________________________ Relationship______________________ Age_____

Name_______________________________ Relationship______________________ Age_____

Name_______________________________ Relationship______________________ Age_____

Mental Health Services

499 Glen Street, Glens Falls, NY 12801 Phone: 518-798-9187/ Fax: 518-223-0567

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client and the particular problems you are experiencing. There are many different methods that may be used to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant parts of one's life, your child may temporarily experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what your child will experience.

Therapy session sometimes involve a large commitment of time, money, and energy so you should be very thoughtful about the therapist you select. Our first few sessions will involve an evaluation of your child's needs and requests so that I can offer impressions and formulate a treatment plan if you decide to continue therapy. You should evaluate this information along with your own opinions of whether you and your child feel comfortable working with me.

Child Therapy Contract

1. If you decide to terminate treatment, I have the option of having a few closing sessions with your child to properly end the treatment relationship.
2. You are waiving your right to access to your child's treatment records.
3. I will inform you if your child does not attend treatment sessions.
4. Periodically throughout treatment and at the end of treatment, I will provide you with a summary that includes a general description of goals, progress, and potential areas that may require intervention in the future.
5. If necessary, to protect the life of your child or another person, I have the option of disclosing information to you without your child's consent.
6. You agree that my role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).
7. 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.
8. If there is a court appointed evaluator, and if appropriate releases are signed and a court order is provided, I will provide general information about the child which will not include recommendations concerning custody or custody arrangements.
9. If, for any reason, I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $250.00 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other court-related costs.

Office Policies and Procedures

1. Therapy sessions are approximately 45-60 minutes with a charge of $60.00-$90.00 per session (individual, couple and family rates apply). Payment is due in full at the time of the appointment for non-insured patients.
2. Proof of insurance is required at time of initial appointment. It is the client's responsibility to inform office staff of any changes in insurance coverage and billing information in order that we may file as a courtesy to you.
3. All deductibles, co-pays and non-covered services are due at the time of service unless payment arrangements have been made in advance. I accept cash and personal checks.
4. In the case that your insurance company denies payment of any claim we file on your behalf we will bill you the denied amount. Payment will be due at your next appointment.
5. Scheduled appointments are commitments. Please make every effort to be on time. If you are late, time will be lost from your session. **If you miss an appointment and fail to notify the office at least 24 hours in advance, you will be charged a missed appointment fee of $50.00** which will be billed to you with payment expected within 15 days of the billing date.

6. All records and communications about the client will be treated confidentially with applicable state and federal laws. These laws may oblige me to report suspected abuse or neglect, domestic violence, and those who pose a danger to themselves or others. Managed care requires that you waive your rights to keep your psychotherapy confidential. They require treatment reports which request information about why you are using your outpatient mental health benefit. They will not authorize and therefore will not pay for sessions without this information.
7. As a therapist, my role is to provide treatment. If you ask me to provide administrative services, you will be charged according to the following fee schedule:
    a. Records request: Seventy-five cents ($.75) per page plus postage.
    b. Treatment summaries: $50. Treatment summaries will be descriptive, not interpretive.
    c. Letters: $50 per letter.
    d. Clinical Reports: $200 per individual included in the assessment.
    e. Telephone calls: Phone conversations will be billed at a rate of $25 per 15 minutes and will be prorated for time exceeding 15 minutes.

Policies for Legal Involvement

1. You agree that my role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).
2. You agree to instruct your attorney(s) not to subpoena me or to refer in any court filing to anything I have said or done.
3. If there is a court appointed evaluator, and if appropriate releases are signed and a court order is provided, I will provide general information about the case which will not include recommendations concerning custody or custody arrangements.
4. If for any reason, I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $250 per hour for time spent traveling, preparing reports, testifying, being in attendance and any other court-related costs.

Informed Consent for Treatment

I, ____, have read and understand the above contract and policies and agree to its terms and give informed consent for treatment.

____ ______________________________

Signature of Parent/Guardian Date

Payment Authorization

__________Bill Insurance __________Self-Pay

I give permission to file with my insurance company. (Yes, No, or N/A) _________________________

My co-pay for outpatient psychotherapy is $___________ My required deductible is $__________

I authorize payment of insurance benefits to be made directly to the provider of services. I further authorize the provider to release, to my insurance company/companies, information from my records that is necessary for the insurance company/companies to process claims for services provided.

____ ______________________________

Signature of Parent/Guardian Date

Client Contact Information

Occasionally, it is necessary for our office to call to discuss insurance information, coordinate/discuss referral to another physician or practitioner, or schedule/change appointments. As a courtesy, our office calls to remind you of appointments. Please note that sometimes we are unable to make reminder calls and **it is your responsibility to keep track of your appointments.**

Telephone number where you want to receive calls ____

Permission to leave a message? ____________________

Can confidential messages (i.e., messages to call the office regarding appointments) be left on your answering machine or voicemail? ___________________

May we call you at your place of employment if you cannot be reached at home? ___________________

Does custodial parent need to be notified if non-custodial parent requests information? ______________

Client Name (please print) ____

Signature____

Relationship to client ____

Acknowledgement of Receipt of Notice of Private Practices

I acknowledge the receipt of the HIPAA Privacy Information found at the end of this packet.

____ ________________________________

Printed Name Date

____

Parent/Guardian Signature

Privacy Office Information

The HIPAA Privacy Officer for this office is Daniah Cornell (518-798-9187). The Privacy Officer:

- Can answer your questions about privacy practices.
- Can accept any complaints you have about our privacy practices.
- Can give you information on how to file a complaint.

Consent for Treatment

Rachel Wolfield, LCSW-R
499 Glen Street, Glens Falls, NY 12801 Phone: 518-798-9187/ Fax: 518-223-0567

My child ____, will be receiving psychotherapy services from Rachel Wolfield, LCSW-R. These services will be confidential in nature with a few exceptions:

- If there is an allegation of child or elder abuse or neglect it will be necessary for me to share pertinent information with the proper authorities.
- If there is an expressed intention to harm yourself or someone else, pertinent information would be shared with proper authorities to prevent such harm.
- Whenever permission has been granted in writing by you or your parent, as applicable, information may be shared with the identified entity.
- Information may be released to third party payers, such as your insurance company's carve-out payment vendor, for the purposes of receiving payment for services. This information will be limited to the information relevant to receive payment.

In addition, Rachel Wolfield, LCSW-R may consult with other mental health professionals in order to provide the best treatment options.

Rachel Wolfield, LCSW-R can be reached at her office during normal business hours on Monday through Friday at 499 Glen Street, Glens Falls, NY, (518) 798-9187. Please leave a message with the secretary or on her confidential voicemail system. She will do her best to return phone calls in a timely manner. However, in the event of an emergency, call 911 or go to your nearest emergency room.

You may also consider calling one of the following resources:

Child Protective Hotline:	800-635-1522
Hopeline:	800-784-2433
NY Domestic Violence Hotline:	800-942-6906
Rape/Sexual Violence Hotline:	800-656-4673
Suicide and Crisis Hotline (Albany):	518-689-4673

The information contained in this document, limitations to confidentially and contact information has been reviewed. I understand that if I have additional questions or concerns regarding these matters, I will ask that they be addressed.

____
Printed Name of Client

____ ______________________________
Signature of Client (12 years of age and older) Date

____ ______________________________
Signature of Parent/Legal Guardian Date

Child Therapy Information

Rachel Wolfield, LCSW-R
499 Glen Street, Glens Falls, NY 12801 Phone: 518-798-9187/ Fax: 518-223-0567

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rule about your child's confidentiality during the course of treatment. The information herein is in addition to the information contained in the Patient-Therapist Agreement. Under HIPAA and the NASW Ethics Code, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain mine. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however, I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. At the end of your child's treatment, I will provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual activity, alcohol and drug use, or other potentially problematic problems. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between parents, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither parent will attempt to gain advantage in any legal proceeding between them from my involvement with your child(ren). In particular, I need your agreement that in any such proceedings, neither parent will ask me 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 filings to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. 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 at the rate of $250.00 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Parent/Guardian Signature ________________________________ Date____/____/_____

Rachel Wolfield, LCSW-R
499 Glen Street, Glens Falls, NY 12801 Phone: 518-798-9187/ Fax: 518-223-0567

RELEASE OF INFORMATION/AUTHORIZATION

Client Name: ____________________________________ DOB: ____/____/____

I do hereby consent and authorize Rachel Wolfield, LCSW-R to exchange my protected health information or the protected health information of my child (whichever is applicable) to the person(s) designated below (i.e., physician, pediatrician, school official, relative, etc.):

Name: ____

Address: ____

Telephone: ____

Fax: ____

☐ I do not wish for my primary care physician or my child's pediatrician (whichever is applicable) be contacted.

By signing below, I am authorizing the exchange of information between providers related to my (or my child's) diagnosis, treatment, and progress for the purpose of coordinating treatment.

This authorization will remain in effect for one year from the date below or until treatment is terminated. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Rachel Wolfield, LCSW-R. However, I understand that my revocation will not be effective to the extent that Rachel Wolfield, LCSW-R has taken action in reliance on the authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of this information and no longer protected by HIPAA or any other federal or state law.

I understand that Rachel Wolfield, LCSW-R will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

____ _____/_____/_____
Signature of Client/Parent/Guardian **Date**

____ ________________________
Printed Name of Client **Relationship to Client**

NOTICE OF PRIVACY PRACTICES (HIPAA INFORMATION)

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

Rachel Wolfield, LCSW-R
499 Glen Street, Glens Falls, NY 12801 Phone: 518-798-9187/ Fax: 518-223-0567

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy in my office and on the True North at 499 website www.truenorthat499glen.com, sending a copy to you in the mail upon request or providing one to you at your next appointment. The Privacy Officer for True North at 499 Glen is Daniah Cornell (518-798-9187).

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: With your written consent only, I will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, your protected health information may be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you, consultation with clinical supervisors or other treatment team members.

For Payment: I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: I may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Business Associates: I may share protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services). Whenever an arrangement between myself and a business associate involves the use or disclosure of your protected health information, I will have a written contract from them that contains terms that will protect the privacy of your protected health information.

Required by Law: Under the law, I must disclose your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization: Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a licensed social worker in this state, it is my practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the NASW Code of Ethics and HIPAA.

Child Abuse or Neglect: I may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings: I may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients: I may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies: I may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care: I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight: If required, I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement: I may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions: I may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health: If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety: I may disclose your PHI if necessary, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research: PHI may only be disclosed after a special approval process or with your authorization.

Marketing: I may use or disclose certain health information in the course of providing you with information about treatment alternatives, health-related services. For example, I may mail you a brochure about meditation classes or workshops. You may contact me to request that these materials not be sent to you.

Fundraising: I may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission: I may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission, only when written permission is not a timely option to ensure your safety.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that I have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to me at 499 Glen Street, Glens Falls, NY 12801.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with us. I may prepare a rebuttal to your statement and will provide you with a copy. Please contact myself and/or administrative staff at True North at 499 Glen if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. I will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, I am be required to notify you of this breach, including what happened and what you can do to protect yourself. A breach is defined as stolen or improperly accessed PHI; sent to wrong provider; unauthorized views of PHI by employee. PHI is unsecured if it is not encrypted to government standards.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to my office at 499 Glen Street, Glens Falls, NY 12801 Attention: Privacy Officer, Daniah Cornell (518) 798-9187, our Privacy Officer; or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **I will not retaliate against you for filing a complaint.**

The effective date of this notice is December 1, 2020.