Hollister Office
309 Snowden Drive
Hollister, MO 65672
(314) 717-0190 Office
(314) 754-7275 Fax

Patient/Client Information

Name:_____ **DOB:**_____

Would you prefer to be referred to as a Patient or Client? Please check one: Client □ Patient □

Sex: Male □ Female □ How did you find me?_____

Address: _____

Email:_____

Significant other/spouse:_____

Phone Nos.:_____

Emergency contact:_____

Medical or mental health providers: [Please provide a list of medications you take, including supplements.]

Psychiatrist_____ **Last seen:**_____

Family care_____ **Last seen:**_____

Other_____ **Last seen:**_____

Counselor:_____ **Last seen:**_____

Insurance: (attach copy of card)

Company:_____ **Policy No.**_____

Group No._____ **Phone:**_____

Name of Insured:_____ **Insured DOB:**_____

Referred by_____

I hereby authorize the release of any medical or other information necessary to process claims to my insurance company. I also authorize payment of medical benefits from my insurance company to Happy Brain Counseling, LLC, for services provided.

_____ **Date:**_____
Signature of patient/client

Or

_____ **Date:**_____
Guardian/Parent

_____ **Date:**_____
Guardian/Parent

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Amanda Campbell, LPC
Email: Amanda@happy-brain.com
Office: 417-344-2934

Amanda Campbell is a Licensed Mental Health Practitioner in the State of Nebraska (inactive) and Provisional Licensed Professional Counselor (P.L.P.C) in Missouri (effective December 2024 she is currently a P.L.P.C. under supervision from Dr. Richard Staley, license 1989COU000883X, expecting full licensure in January 2025). Mrs. Campbell earned her graduate degree in School Counseling, from Evangel University, in Springfield, MO, in 2014. Amanda has worked with adults, children, couples, and families for over a decade in private practice, supporting children in foster care, and as a school counselor. She is experienced working with school teachers, administrators, and community officials to support challenging behaviors and to support healing and growth. She is certified to treat addiction with the American Society of Addiction Medicine and Missouri Associate Alcohol Drug Counselor (MADDC II). Amanda is EMDR trained to treat trauma and support children using Play Therapy (RPT Candidate, certification pending).

Amanda is trained in many modalities including Play Therapy, EMDR, Acceptance and Commitment, Solution Focused, among other modalities to support ADHD, Autism, Anxiety, Depression, Addiction, Trauma, Adjustment Disorders, and Personalities. Mrs. Campbell specializes in addiction and substance abuse, offering SMART recovery groups and individual support, trauma support for adults and children and offers a Woman's Trauma Support Group, which includes EMDR to support healing. She also specializes in Parental Alienation and Estrangement, supporting high conflict parents, even those in custody disputes, to support family unity and children who are alienated or estranged from a parent.

Amanda's approach is gentle, collaborative, and tailored to each individual or family, with a goal of helping clients feel seen, understood, supported without judgment, and equipped with tools to empower and create a positive outcome and healing. She believes every person and family can heal and thrive in a safe and supportive space.

Amanda Campbell accepts self-payments and a variety of insurance.

To schedule an appointment with Amanda, please call Alanna, the office manager, at 314-717-0190, or email Alanna@happy-brain.com.

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Camille Bruton Reinhold, LPC, LCPC
Email: Reinhold@happy-brain.com
Office: 314-717-0190

Camille Reinhold is a Licensed Professional Counselor (LPC) with the State of Missouri and a Licensed Clinical Professional Counselor (LCPC) with the State of Illinois (pending). Prior to licensure, Camille received a graduate degree in Counseling and Family Therapy, with a focus on human development, at Saint Louis University in January 2009. In May 2011, she received an Executive Masters of International Business from Saint Louis University and am certified by the American Board of Quality Assurance and Utilization Review Physicians in Health Care Quality and Management (CHCQM). Camille is certified to work with personality disorders and to work with high conflict blended families. She is a certified NET (Neural Emotional Technique) provider.

As a counselor, Camille believes that you know yourself better than anyone and that you possess the skills necessary to identify problems that you would like to change and to make the necessary adjustments you believe to be important. Thus, she will collaborate to identify therapeutic goals. Camille believes that her job as a therapist is to help you to identify those problems by allowing you to tell your story and then to help you to alter this story in the way you choose and that works for you. This is a narrative approach to therapy. She is also influenced by emotion-focused therapy, which concentrates on identifying emotions that generate anger, depression, and anxiety. This therapy has been well researched and is documented to create benefits for individuals and couples by using emotions and thoughts to create positive changes. Camille frequently works with children and adolescents and uses Play Therapy to put children at ease and to create a bond of trust with them. With families, Camille uses a family therapy model that works with family members individually and in dyads to improve relationships and encourage positive relationships where repair is possible. NET works with the mammalian brain to identify emotions that are getting in the way of optimal cognitive and emotional performance. NET is highly researched and is proven to stop amygdala activity in the brain post emotional trauma.

Camille has specialized training with high Conflict blended families to support the community at the family level. Divorce is so hard on parents, that often one parent will either cause children to unjustifiably disrespect another parent, or one parent can be toxic and the children can be naturally estranged from that parent, a justified break in the relationship.

When relationships do not work, Camille offers divorce mediation to promote a return to well-being when the marriage ends. This approach is particularly designed to help parents work with children when one home becomes two homes. This focus reduces confusion, anxiety, and tensions for the couple and the children as they begin a new life. She works with an attorney offering a special rate to couples with or without children and who are agreeing to a non-contested approach to settling their differences. This process causes harmony between the two houses

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and for all members of the family.

Camille is self-pay only at a rate of $255 per session. She has limited in person availability in Hollister, MO.

To schedule an appointment with Camille, please call Alanna, the office manager, at 314-717-0190, or email Alanna@happy-brain.com.

About All Therapists

We will try to return all calls within 24 hours. It is important that we are aware of any change in your address or telephone numbers to allow for my prompt care.

At the first session, we will review with you the goals and direction of therapy and parties that will be involved. It is possible that during therapy we will review our goals and readjust the parties involved in therapy, such as a move from working with a couple to working with a family. In any transition, we will review together the ethics, relationships between the parties, and emotional safety of the parties in these types of transitions, and whether the parties would be better served working with another mental health professional. When working with children, we always strongly encourage the participation of both biological parents, although there are some exceptions to this, and appreciate the support and the involvement of the entire family, including stepparents. When working with children and families, there may be times that we work with parties alone or in different dyads together, including the entire family with stepparents.

There are times that we work with multiple parties within a family individually. Confidentiality is not individual in these cases and is restricted to the couple or the blended family. It is important to us that each person is emotionally safe. If at any time you do not feel emotionally safe, please notify your therapist, and discuss the best methods to resolve your concerns. Because of our desire to protect the sanctity of the therapeutic relationship, we do not provide therapy records to individuals or parents, and particularly blended parents, without a release from each adult with whom we have worked and a Court Order. Third party payers may not condition payment on receiving a copy of these records and there is a statutory fee for electronic and paper records. Further, recording of sessions is prohibited without written permission from your therapist in advance. Failure to comply with this policy will result in a $500 charge and termination of care.

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To ensure emotional safety for families, it is important that all parties are compliant with therapy. Therapists may terminate the therapy for non-compliance or issues above our competency. Non-compliance would include disrespect for the mental health professional or other members of the family. Disrespect could include, among other things, name calling, yelling, or screaming. If charges are incurred from breaking equipment, failure to return items loaned, or legal fees, these items are Page charged to the client as expenses are incurred. In some cases, the dysfunction of the family could be too severe for the private practice therapeutic setting and the therapist may refer a person or persons to more comprehensive care.

In order that we may provide consistency with your current medical or mental health care, it is important that we are aware of all medical or mental health care professionals that you are currently seeing or that you have seen in the past. Most of the time, we will acquire a release from you to discuss their care provided and/or to receive a summary of care provided or their records.

To support our clients, we accept some insurance. This does not mean that the patient is not responsible for payment at the time of service. If insurance fails to pay or does not timely pay, we will charge the patient for the allowable insurance charge for each date or service, or same day cancelled or missed appointments. New clients are charged the allowable insurance payment at the time of service until insurance payments are made and those costs are credited to the patient when insurance completes the payment.

I have reviewed this information with the therapist, and I agree to the above terms and understand there are no exceptions to these terms and conditions:

Date:_____ Client Signature:_____

Date:_____ Therapist Signature:_____

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Office Information and Policies

Regarding Confidentiality

The privacy and confidentiality of your therapy is very important. Information shared between the client/patient and therapist remains private and is protected health information. There are exceptions, however, when this protected information must be shared with others. These exceptions include:

1) Insurance purposes: A diagnosis/treatment plan is required to justify payment. The treatment plan includes a statement of the problem for which you sought treatment, your psychiatric diagnosis, symptoms to justify the diagnosis, alcohol and drug use, a mental health treatment history, a list of current medications, treatment goals, progress notes, and interventions used. No release is required.
2) Consultation: In your best interest, I will be consulting on a regular basis with other professionals about your case. A release will be gathered from you.
3) Legal and ethical issues: Missouri state law requires all therapists to report any suspected cases of children abuse to the Division of Family Services. Further, therapists have a duty to report any suspected intent to harm yourself or others. If the therapist believes it is necessary, the potential victim, medical/psychiatric health care professionals, the police, or anyone else the therapist believes should have this information will be notified. No release is necessary.

Regarding Fees and Payment

A full session is 50 minutes, depending upon your insurance requirements and your therapist. Some insurance is accepted, and we require the full allowable fee at the time of service. We will reimburse insurance payments to you. We accept self-pay amounts determined by the sliding scale fee on page eight. Camille Reinhold is only self-pay at $255, for 50 minutes. Payment in full is expected at the time of service. In case of treating minor children, the parent(s) or guardian is(are) held responsible for payment at the time of service. Outstanding account balances in excess of $200 may cause an interruption in care, at the discretion of the therapist. Fees unpaid for more than three months will be sent to collection and attorney's fees will be payable by the client.

We do not wish to go to Court because it interrupts the emotional safety of the therapeutic relationship. In the event the therapist is subpoenaed for court appearance/testimony or for deposition testimony we charge a non-refundable flat fee of $2,500, per day, required the Friday before the event, due to weekend preparation time requirements. We prefer to write a report for the Court and charge $150 per hour to do so, with a $500 minimum. In the event we require legal representation, you agree to pay for those costs when incurred.

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Office Information and Policies

There are times that we collaborate with other parties, such as legal counsel, Guardian *ad Litem*, physicians, teachers, and the like. For legal consultations, we charge $150 per hour for the portions of time that we consult and for medical and school professionals we charge in accordance with the self-payment amount or insurance allowable, as an out-of-pocket fee. Any attorney's fees required for litigation or defense of the therapist or agency will be charged to the client at the time the invoice is payable.

Canceled or Missed Appointments

Scheduled appointments are times specifically held for the patient/client. **Cancellations must be made 24-hours in advance of the appointment to avoid a fee.** Please remember our goal is to allow another person on the waiting list to be scheduled for that canceled appointment. **The fee for missed appointments or same day cancellations is the full cost of the session [self-pay or insurance plus co- payment amount].** Repeated failed appointments or late cancellations may result in your therapy being canceled**. Please note insurance does not pay for missed appointments and it will be charged to the client.**

Office Hours and Contact Information

If we are unavailable or if you are calling after hours every effort will be made to accommodate your needs within 24 hours. If you have an emergency, please contact 911, and/or go to the nearest emergency room, and/or call one of the following numbers: Behavioral Health Crisis Line (314) 469-6644 or Life Crisis Services (314) 647-4357.

Please understand there are no exceptions to these policies.

Self-Payment Sliding Scale Fee For All Counselors Except Camille

If you are using insurance, please skip to the Attestation section below. The self-payment advantage is your mental health care will truly be confidential and not shared with your insurance company. If you are using self-payment, please choose the self-payment amount that applies to you based upon your household income, meaning the total annual income by those living in your household. Please check the box that corresponds to your household income.

Please note that Camille Reinhold does not accept a sliding scale fee and her fee is $255.

Annual Household Income	Self-Payment Amount	Check (√)
$100,000 or more	$165	
$80,000 - $99,000	$135	
$79.000 or less	$105	

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ATTESTATION

This section applies to the entire document.

I have read and understand the above office polices and agree to these polices. I understand I am responsible for all charges, regardless of insurance coverage. I further agree to receive therapeutic services.

Date:_____ Client Signature:_____

I have thoroughly reviewed these office policies and informed consent with my therapist:

Date:_____Signature:_____

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Card Payment Authorization Form

Sign and complete this form to authorize Happy Brain Counseling, L.L.C., to debit your credit/debit card listed below. By signing this form you give us permission to charge your account for the amount indicated as payment for the specified co-payment for each session and/or for the amount indicated as payment for missed or canceled appointment in accordance with your agreement with Happy Brain Counseling, L.L.C..

Please complete the information below:

I_____authorize Happy Brain Counseling, L.L.C., to charge my credit/debit card account indicated below for invoiced copayment amounts each counseling/therapy session with Happy Brain Counseling L.L.C. I further authorize Happy Brain Counseling, L.L.C. to charge my credit/debit card for copayments, self-payments, and missed or same-day cancellations.

Billing Address_____ Phone#_____

City, State, Zip_____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3-digit number on back of Visa/MC) _____

SIGNATURE_____ DATE _____

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company so long as the transaction corresponds to the terms indicated in this form.

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HIPAA Consent Form

This document is a notice of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and prepared by Happy Brain Counseling, LLC to help you understand your privacy rights. You may also review the full and complete HIPAA document prior to signing this consent. The Notice of Privacy Practices is posted in the waiting room, as legally required, and describes your privacy rights and how protected health information about you may be used by me and may be disclosed to others for the purpose of treatment, payment, health care operations, or for an appointment reminder. Signing this form will give you the right to request that I restrict how protected health information is used and disclosed for treatment, payment, health care operations, or appointment reminders. This restriction is binding.

There are circumstances where your information is used without your prior and express permission:

1. When I am required by law to involuntarily treat you;
2. For public health or safety issues;
3. As required by State, Federal, or local law; and,
4. For law enforcement.

Even in these instances, I will, if at all possible, keep you informed.

You have the right to inspect records but this does not include psychotherapy notes or information compiled in anticipation of litigation. Psychotherapy notes are defined as detailed notes recorded by a mental health professional, documenting or analyzing the contents of conversations during a private, couples, family, or group counseling session. To inspect and/or copy mental/medical health records you must submit your request in writing to me, using a valid HIPAA release of information, which form I can provide to you upon request. Upon your written and valid request for medical records, I have 45 days (RSMo. Section 191.227) to provide such records and I will charge the legally allowed fee for such copies, or a $25.00 administration fee plus $.15/page (RSMo. Section 191.227).

I reserve the right to change the Notice of Privacy Practices, which is also posted in my waiting area, and it is effective per the date on the top right-hand corner. Disclosure of your health information that is not covered in the Notice of Privacy Practices will not be made without your written authorization. If you provide me with written authorization to use or disclose information, you can change your mind and revoke your authorization at any time and only in writing. If you revoke your authorization, I will no longer use or disclose information about you; however, I will not be able to take back any disclosures made pursuant to your previous authorization. If you believe your privacy rights have been violated, you may report the problem to HIPAA on their website at www.HIPAA.uab.edu.

I have reviewed this HIPAA Consent Form and the attached Notice of Privacy Practices with Happy Brain Counseling, L.L.C.:

Date:_____ _____
Client name printed:

_____
Legal guardian name printed:

Date:_____ _____
Happy Brain Counseling, LLC

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
[*45 CFR 164.520*; http://www.hhs.gov/ocr/hipaa/guidelines/notice.pdf]

Notice of Privacy Practices
THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice of Privacy Practices describes how Happy Brain Counseling, L.L.C., and its employees, independent contractors, affiliates, volunteers, clinic and third-party contractors may use and disclose your protected health information (PHI) for purposes of treatment, payment and health care operations, and for other purposes that are permitted or required by law.

I. RESPONSIBILITIES:
The Counselors at Happy Brain Counseling, L.L.C., value your privacy and the privacy of your information. This clinic is required by law to maintain the privacy of your health information and provide you with this Notice of Privacy Practices. This clinic will abide by the terms of this Notice of Privacy Practices. We reserve the right to change this Notice of Privacy Practices and to make any new Notice of Privacy Practices effective for all protected health information that we maintain. Any new Notice of Privacy Practices adopted will be posted in the waiting area and any breech of your privacy will be reported to you.

II. WHAT IS "PROTECTED HEALTH INFORMATION" (PHI)?
Protected health information ("PHI") is demographic and individually identifiable health information that will or may identify the patient and relates to the patient's past, present or future physical or mental health or condition and related health care services.

III. WHAT DOES "HEALTH CARE OPERATIONS" INCLUDE?
Health care operations include activities such as communications among health care providers, conducting quality assessment and improvement activities; making travel arrangements to and from this clinic; coordinating temporary housing; evaluating the qualifications, competence, and performance of health care professionals; training future health care professionals; contracting with insurance companies: conducting medical review and auditing services; compiling and analyzing information in anticipation of or for use in legal proceedings; and general administrative and business functions.

IV. HOW IS MEDICAL INFORMATION USED?
This clinic uses medical records as a way of recording health information, planning care and treatment and as a tool for routine health care operations. Your insurance company may request information such as procedure and diagnosis information that we are required to submit in order to bill for treatment we provide to the patient. Other health care providers or health plans reviewing your records must follow the same confidentiality laws and rules required of this mental health clinic.

Patient records are also a valuable tool used by our researchers in finding the best possible treatment for diseases and medical conditions. All mental health researchers must follow the same rules and laws that other health care providers are required to follow to ensure the privacy of patient information. Information that may identify patients will not be released for research purposes to anyone outside of this clinic without written authorization from the patient or the patient's parent or legal guardian.

V. EXAMPLES OF HOW MEDICAL INFORMATION MAY BE USED FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

- Medical information may be used to justify needed patient care services, (i.e., lab tests, prescriptions, treatment protocols, research inclusion criteria).
- We will use medical information to establish a treatment plan.

- We may disclose protected health information to another provider for treatment (i.e. referring physicians, specialists and providers).
- We may submit claims to your insurance company containing medical information and we may contact their utilization review department to receive pre-certification (prior approval for treatment).
- We may use the emergency contact information you provided to contact you if the address of record is no longer accurate.
- We may contact you to remind you of the patient's appointment by calling you or sending an email or postcard.
- We may contact you to discuss treatment alternatives or other health related benefits that may be of interest.
- We may use information for making travel arrangements to and from this mental health clinic.
- We may use information to coordinate temporary housing at such facilities as Ronald McDonald House, Target House, Our Lady's Inn, and / or local hotels.
- The patient's name, home address, location, and dates of service.

VI. WHY DO I HAVE TO SIGN A CONSENT FORM?

When you, as the patient or the parent or guardian of a patient, sign a consent form, you are giving this clinic permission to use and disclose protected health information for the purposes of treatment, payment, and health care operations. This permission does not include psychotherapy notes, psychosocial information, alcoholism and drug abuse treatment records and other privileged categories of information which require a separate authorization. You will need to sign a separate authorization to have protected health information released for any reason other than treatment, payment, or healthcare operations.

VII. WHAT ARE PSYCHOTHERAPY NOTES?

Psychotherapy notes are notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session that are separated from the rest of the patient's medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

VIII. WHAT IS PSYCHOSOCIAL INFORMATION?

Psychosocial information is information provided to your social worker regarding your family's social history and counseling services you have received.

IX. WHY DO I HAVE TO SIGN A SEPARATE AUTHORIZATION FORM?

To release patient protected health information for any reason other than treatment, payment and health care operations, or as otherwise provided by law, we must have an authorization signed by the patient, or the parent or guardian of the patient, that clearly explains how they wish the information to be used and disclosed. The following are some examples of releases of information that require a separate authorization:

- Psychotherapy notes.
- Psychosocial information.
- The sharing of information and photographs for fundraising and public relations purposes.
- Use of information in scientific and educational publications, presentations and materials related to the work at this mental health clinic.
- The sharing of information with other clinical and scientific cooperative groups that this clinic collaborates with to further care through research, education, and treatment.
- Uses and disclosures of psychotherapy notes or information for marketing purposes.
- Uses and disclosures of psychotherapy notes that would constitute a sale of psychotherapy protected information or other uses not described in this document.

X. CAN I CHANGE MY MIND AND REVOKE AN AUTHORIZATION?

You may change your mind and revoke an authorization, except (1) to the extent that we have relied on the authorization up to that point, (2) the information is needed to maintain the integrity of the research study, or (3) if the authorization was obtained as a condition of obtaining insurance coverage. All requests to revoke an authorization should be in writing.

XI. SHARING INFORMATION WITH ASSOCIATES

There are some services provided to this clinic through contracts with business associates. Examples include billing services, transcription services, etc.. When these services are contracted, we may disclose your health information to the business associate so that they can perform the job we have contracted them to do. To protect your health information, we contractually require our business associates to follow the same confidentiality laws required of this clinic.

XII. WHEN IS MY AUTHORIZATION / CONSENT NOT REQUIRED?

The law requires that some information may be disclosed without your authorization in the following circumstances:

- In case of an emergency
- When there are communication or language barriers
- When required by law
- When there are risks to public health
- To conduct health oversight activities
- To report suspected child abuse or neglect
- To report SIDS
- To specified government regulatory agencies
- In connection with judicial or administrative proceedings
- For law enforcement purposes
- To coroners, funeral directors, and for organ donation
- In the event of a serious threat to health or safety

XIII. YOUR PRIVACY RIGHTS

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

1. You have the right to inspect and copy your health information.

This means you may inspect and obtain a copy of your PHI that is contained in a “designated record set” for so long as we maintain the PHI. A designated record set contains medical and billing records and any other records that this clinic uses in making decisions about your healthcare. You may not however, inspect or copy the following records: psychotherapy and psychosocial notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and certain PHI that is subject to laws that prohibit access to that PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have the right to have this decision reviewed. Please contact the HIPAA Privacy Officer if you have questions about access to your medical record.

2. You have the right to request a restriction of your health information.

This means you may ask us to restrict or limit the medical information we use or disclose for the purposes of treatment, payment, or healthcare operations. Kelly Locker, P.L.P.C., or other Counselors at Happy Brain Counseling, L.L.C., are not required to agree to a restriction that you may request. We will notify you if we refuse your request. If we do agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting the HIPAA Privacy Officer.

3. You have the right to request confidential communications by alternative means or at alternative locations.
We will accommodate reasonable requests. We may also condition this accommodation by asking you for an alternative address or other method of contact. We will not request an explanation from you as the basis for the request. Requests must be made in writing to the HIPAA Privacy Officer.

4. You have the right to request amendments to your health information.
This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with the HIPAA Privacy Office and we may prepare a rebuttal to your statement and will provide you with a copy of this rebuttal. If you wish to amend your PHI, please contact this clinic and/or the HIPAA Privacy Officer. Requests for amendment must be in writing.

5. You have the right to receive an accounting of disclosures of your health information.
You have the right to request an accounting of certain disclosures of your PHI made by this clinic. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for our Hospital Directory, to family or friends involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to this clinic or the HIPAA Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2017. Accounting requests may not be made for periods of time more than six years.

6. You have the right to receive a paper copy of this Notice of Privacy Practices.

XV. WHAT IF I HAVE A QUESTION / COMPLAINT?

Please contact Camille Reinhold via the telephone provided to you and provide a written summary of your question or complaint. If you have additional questions or concerns, please contact the HIPAA privacy officer for this region of Missouri within 180 days of the complaint:

Region VII
Office for Civil Rights
U.S. DHHS
601 East 12th Street, Room 248
Kansas City, MO 64106
(816) 426-7277 Office
(816) 426-7065 (TDD)
(816) 426-3686 Fax