

Navigate Changes

Elisabeth Caetano, M.A., M.F.T. #37010

16870 West Bernardo Drive, Suite 404 * San Diego, CA 92127

(619) 687-9013 * Fax (858) 538-2238 * Navigate.changes@gmail.com

Client Information

Name _____ Phone(Cell) _____

Address _____ ZIP _____

Email _____

Date of Birth _____

Employer _____ Monthly Gross Income _____

Employer's Address _____ Occupation _____

I wish to communicate via email/text Yes _____ No _____

Client's Immediate Family (Living in the home)

Name	Date of birth	Marriage/Divorce/Custody Arrangements	Telephone #

Nearest relative other than spouse (to call/contact in case of emergency)

_____ Relationship _____ Phone _____

Address _____ Zip _____

Financial Agreement

Elisabeth Caetano's standard fee is \$175 per 50 minute hour. Payments due in full at the beginning of each session. If I encounter a problem with the payment of fees, I shall discuss it with Elisabeth Caetano, MA immediately. I agree to pay all fees for services rendered at the time of service. This time has been reserved for you. A 24 hour notice of cancellation is required or it is standard policy to pay full session fee of \$175.00, which I agree to pay. **(Initial here)**_____

Bounced Check Policy

I understand that I will be charged a \$35 fee for any check that is returned to Elisabeth Caetano for Non-sufficient Funds. If two checks are returned to me NSF, cash payments will be required.

Electronic/Internet Credit Card Processing Authorization Form

This office requires that all patients have a valid credit card on file even if you choose to pay by cash or check. Please include a credit card number on this form. *Please note I do not accept DEBIT credit cards.

Forms of Payment Available:

I accept the following forms of payment: Visa, MasterCard, & Discover as well as checks and cash. Please indicate your preferred form of payment on this *Electronic Payment Authorization* form. I prefer to pay with: Check_____ Cash_____ Credit Card_____

The Electronic Payment form will be securely stored in your clinical file and may be updated upon request at any time. Elisabeth Caetano will deduct your session fees from the credit card designated on this form if you would like to utilize this form of payment. This office uses the on-line system "Therapy Partner" or "Square Register" to process all credit cards. **Please be aware that all transactions will read 'Therapy Partner Corporation,' on your bank or credit card statement or Elisabeth Caetano via Square Register.** Therapy Partner and Square Register are the third party merchants who process your credit card.

I would like to use the following credit card: MC_____ Visa_____ Discover_____

Card number_____ Exp_____ CCV_____

Name as it appears on card_____

Monthly Statements:

Clients can receive monthly statements via email for all sessions attended within a calendar month *upon request*. Clients can also log into Therapy Partner billing system to generate and print statements for any time period by accessing the following web address: <http://www.TherapyPartner.com>. Square Register emails or texts a receipt immediately upon payment. I would like an email statement from Therapy Partner/Elisabeth Caetano. Y N

Confidentiality and Payment

By signing below, I authorize Elisabeth Caetano, MA, MFT #37010 to release only my personal information to Therapy Partner and/or Square Register, that is necessary for Therapy Partner/ Square Register to bill my credit card. Release of my personal information is for the sole purpose of payment for services rendered from Elisabeth Caetano, MA, MFT #37010.

By signing below, I authorize Elisabeth Caetano, MA, MFT #37010 to charge my credit card for co-pays with insurance, \$175.00 per therapy session **in the event that insurance does not cover services**, \$175.00 for no shows, and \$175.00 for less than 24 hour notice cancellation. I have read and understand the above information and have discussed any questions that I had with Elisabeth Caetano, MA, MFT #37010.

***Client Signature**_____ **Date**_____

Informed Consent - (Client's Rights & Responsibilities)

I am a licensed MFT with the State of California #37010. I can be reached by leaving a message on my pager at anytime (619) 687-9013, however, I only return calls between the hours of 8am-5pm, Tues-Fri. I will make every effort to return your call within 24-48 business hours. I do not do crisis or after hours counseling. If you need to speak with someone immediately, due to a crisis, you can call the San Diego 24 hour hotline at 1-888-724-7240 or dial 911. I have office hours between 9am-3pm Tuesdays through Fridays and do not work on evenings, weekends or major holidays.

Confidentiality

Information about you is generally held in confidence by law. My policy is never to release information outside of sessions. However, as your therapist I am compelled by ethics and/or law to release information under one or more of the following circumstances:

1. In cases of suspected child abuse, dependent adult or elder abuse
2. When you waive your confidentiality (Example you waive your confidentiality when using your insurance company because the insurance company needs your information in order to pay the claim)
3. When contemplating a harmful act to self, others or a crime
4. When you tender your mental or emotional state in a legal proceeding
5. Following a court order

I will need to communicate with you via snail mail, email, text and telephone. By initialing here, you give me permission to contact you in these forms. **(Initial)** _____

Email / Internet and Confidentiality

Elisabeth Caetano, MA, MFT will not respond to email/text unless it is to set up/cancel an appointment. Additionally no therapy is administered email/telephone/text or on the internet nor is advice given. *Note, that email/internet/texting is NOT confidential.

Additionally, Elisabeth Caetano, MA, MFT is listed on social media & professional websites for purposes of marketing. Elisabeth Caetano, MA, MFT will NOT "friend" clients on Facebook, respond on Twitter, or respond to clients through any social media. If you, as the client, choose to follow inspirational quotes on twitter or any other social media sites that Elisabeth Caetano, MA, MFT is associated with, you as the client, understand and waive any confidentiality that you have by posting your own name to the site. You as the client, agree not to hold Elisabeth Caetano, MA liable for your signing up to "follow", "like" or otherwise participate on social media website and advertising sites with Elisabeth Caetano, MA. All information listed on all social media & advertising is not therapy nor is it intended as a substitute for therapy. I understand the limits to confidentiality with regards to the internet, texting and social media and agree to not hold Elisabeth Caetano, MA, MFT liable for my actions on the internet or texting. **(Initial)** _____

Telehealth

Telehealth is an available service. Elisabeth Caetano uses a company called doxy.me for HIP-PA compliant/confidential sessions. You will be sent a link the day of the session to click and go into a virtual waiting room for your 50 minute session. Fees are the same for all virtual 50 minute sessions.

Reports & Legal Issues

Should you require a written report of your therapy for legal or other circumstances, you will be charged my standard hourly fee of \$175 for each hour and any part thereof for the preparation and writing of the report. If Elisabeth Caetano is called for deposition or to testify in any legal proceedings that I am involved in, I understand that I am responsible for paying the hourly fee of \$200, including transportation time door to door, preparation time for deposition or court and any other court related fees. Any consultation, or work done on your case outside of the therapy session will be billed at \$175 per hour.

Cancellations

Your scheduled appointment has been reserved for you. Should you need to cancel an appointment, a 24-hour notice of cancellation is **required**. Without a 24 hour cancellation, I understand that I am responsible to pay the full session fee of \$175.00. I understand that insurance companies & *EAP's do not pay for cancellation or no show fees and that I am responsible for the full session fee.

Insurance / EAP's

Elisabeth Caetano does not bill ANY insurances. You will need to submit your paid bill (provided to you by Elisabeth Caetano) to your own insurance company for what is called "Out of Network" benefit reimbursement. When you call your insurance company they will tell you that benefits are not a guarantee of payment. They also will not pay for coaching. I will be assessing you to see if you have symptoms that warrant a mental diagnosis in the psychotherapy arena. If I assess that you DO have symptoms to give you a mental diagnosis, it still does not mean that the insurance company will pay for your mental health services. Insurance companies only pay for limited mental health diagnoses. If I assess that you do NOT have symptoms that warrant a mental diagnosis, then your mental health benefits will not pay for services. Additionally any mental diagnosis that you are given that is submitted to the insurance company, goes on your permanent mental health records. It is your decision whether or not to submit claims through your health insurance. In either case, you are responsible for the payment due on services rendered on the day of your session.

1) EAP's pay for a certain pre-approved number of sessions and you must have pre-approval before the first EAP session in order for it to be fully covered by your EAP.

2) I am using my EAP services: Yes _____ No _____
EAP Company name _____ Auth# _____

3) I understand that Elisabeth Caetano does not take any insurance and that I will be provided a superbill to submit to my insurance company for any possible reimbursement that my insurance may or may not cover.

- 4) I understand that any and all of my information may be released to my insurance company/EAP in order to obtain payment on my claim. I understand that by signing below, I authorize Elisabeth Caetano, to release information to my insurance company and/or EAP. Further, I understand that my insurance company/EAP may deny (not pay for) services and if this should be the case I understand that I, myself, am responsible for the full session fee of \$175.00.

COVID Informed Consent

Thank you for continuing to trust in my practice. As with the transmission of any communicable diseases like a cold or the flu, you may be exposed to COVID-19, (also known as “coronavirus”) at any time or in any place. Be assured that I have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in my office and continue to do so.

Despite my careful attention to sterilization, disinfection, and use of personal masks, there is still a chance that you could be exposed to an illness in my office, just as you might be at your own grocery store or at other appointments. “Social distancing “nationwide has reduce the transmission of coronavirus and I have taken measures to provide social distancing in my office. Although exposure is unlikely, do **you accept the risk and consent to working with me?**

Yes _____ No _____

If you have been exposed to a communicable disease, you may spread the disease to other persons in my practice. Therefore, I will be asking the following questions to reduce the chances of transmission:

Have you, your child(ren), others in your home, others accompanying you to today’s appointment or other recent acquaintances **tested POSITIVE** for or been **diagnosed as having COVID-19** or any other communicable diseases?

Yes _____ No _____ If yes, when? _____

Do you have any of the following symptoms for your first session:

A fever or chills (defined as above 99.6°)? Yes _____ No _____

A cough? Yes _____ No _____

Shortness of breath and/or trouble breathing? Yes _____ No _____

Persistent pain, pressure, or tightness in the chest? Yes _____ No _____

Headache or sore throat? Yes _____ No _____

Loss of taste or smell? Yes _____ No _____

I understand that if the answer to any of these questions is yes at any time, I will be asked to reschedule my appointment.

About a Coaching/Counseling

Participating in coaching counseling can help you learn new and important things about yourself and others as well as new and better ways of handling feelings and then tools for taking action. While there are no guarantees, coming to counseling should help you to feel better and produce beneficial results, especially when coupled with taking action.

You know coaching counseling is working when you feel less worried, afraid, or anxious; problems are being resolved, relationships are improving, or you start to feel better about yourself. Sometimes you may feel worse, before you feel better. This is part of the therapeutic process and usually means that you are making progress. You have the right to end coaching counseling at any time.

Coaching vs. Counseling/Therapy

What is Coaching? Coaching is action & goal oriented and is heavily borrowed from Cognitive Behavioral Therapy, however it only asks questions. Counseling/Therapy has a psychological foundation and theory and there are many forms of treatment. Counseling asks questions but also helps understand patterns of behavior and develops insight. I primarily practice CBT, mindfulness & EMDR (Eye Movement Desensitization & Reprocessing). What I have found works best for people is a combination of therapy, teaching and coaching counseling which equates to taking action to promote positive change!

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge receipt of the Notice of Privacy Practices that I have given to you (included at the end of this packet). My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me or if you have any questions about my Notice of Privacy Practices, HIPAA If you have any questions about my Notice of Privacy Practices, please contact me at: 16879 West Bernardo Drive, Suite 404, San Diego, CA 92127. 619-687-9013 or navigate.changes@gmail.com

I acknowledge receipt of the Notice of Privacy Practices from Elisabeth Caetano_____

Initial

I have read, agree with, and understand, all of the terms and conditions stated above. I agree to pay for all services provided, up until the time that therapy is completed. All of my questions have been answered fully, and I understand and agree to all of the terms and conditions of this agreement.

_____	_____	_____
Client Signature	Printed Name	Date

_____	_____	_____
Client Signature	Printed Name	Date

As the therapist, I have discussed the above terms and conditions with the client. My observations of this person's behavior and responses give me no reason to believe that he/she is not fully competent to give informed and willing consent for treatment.

_____	_____
Therapist Signature	Date

☐ Offered copy to client ☐ Client wishes copy to be kept in file ☐ Client received copy

Please read and answer the following questions

1) Marital Status: Single_____ # Years_____

Married_____ # Years_____

Living w/ Significant

Other_____ # Years_____

Divorced_____ # Years_____

2) Education: H.S. _____ B.A. _____ M.A./ M.S. _____ Ph.D. _____ Other _____

College Major (s) _____ Special Training _____

Spouse/ Partner Education _____

3) Religious Affiliation _____ Spouse/Partner's Religion _____

How actively do you participate in your religion? _____

4) Do you or your Spouse/Partner have any significant health problems? (Please list)

5) Are you taking any medications? Please list name, dosage, and reason for medication and how long you have been taking the medication? _____

6) What is your Ethnic heritage? _____ Parents? _____

Parents birthplace (if not USA) _____

Where you born in the United States? Y N

If you were not born in the USA, where were you born and when did you come to the USA and how old were you? _____

Cultural/Ethnic background Spouse _____ Spouse Parents _____

7) How many drinks do you have per day?_____ Spouse/Partner's #?_____

Do you or your spouse have a problem with alcohol or prescription drugs? Y N

Do you or your partner use any recreational drugs? Y N Spouse? Y N

If yes, what drug/s and how often_____

Have you/spouse participated in any substance abuse programs? Y N

If yes, when & where?_____

8) Have you had any previous counseling or psychotherapy? Yes_____ No_____

If yes, when and for what purpose? _____

What did you get from this experience?_____

9) What is your reason for seeking counseling today? _____

10) Are there any other things that you would like me to know?

Checklist of Concerns

Please mark each box that applies to you and circle each symptom on the line that is a current concern. You can add notes to the side if necessary.

- ☐ Depression, low mood, sadness, crying
- ☐ Suicidal thoughts or actions
- ☐ Homicidal thoughts or actions
- ☐ Anxiety, nervousness, panic attacks, fears, phobias
- ☐ Loneliness, isolating yourself
- ☐ Memory problems
- ☐ Mood swings, over emotionality
- ☐ Sleep problems: Too much sleep, insomnia, nightmares, early morning waking
- ☐ Addiction: Alcohol, drugs, food, gambling, internet, sex, porn,
- ☐ Anger, hostility, arguing,
- ☐ Increased irritability
- ☐ Attention: Inability to concentrate, distractibility, hyper focused
- ☐ Impulsiveness: Loss of control, outbursts, rash decisions
- ☐ Eating problems: Overeating, lack of appetite, vomiting, using laxatives
- ☐ Health issues
- ☐ Relationship issues, interpersonal conflicts
- ☐ Poor communication
- ☐ Marital problems
- ☐ Sexual Issues: Dysfunctions, lack of desire, hyper desire
- ☐ Divorce, separation, custody issues,
- ☐ Parenting Issues: Conflict with children, split parenting
- ☐ Current or past abuse: Physical, sexual, emotional, intellectual, spiritual
- ☐ Traumatic memories
- ☐ Obsessions and/or compulsions
- ☐ Oversensitivity to rejection
- ☐ Perfectionism
- ☐ Overly dependent
- ☐ Inferiority feeling, low self-esteem
- ☐ Fatigue, tiredness, low energy
- ☐ Feelings of guilt
- ☐ Grieving, mourning, deaths, losses
- ☐ School: Poor grades, lack of concentration, social issues, problems with teachers
- ☐ Work concerns: Unsure of goals, unemployment, overworking, can't keep a job
- ☐ Legal concerns
- ☐ Financial concerns: Debts, impulse spending, low income

Notice of Privacy Practices For Your Records

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

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (if applicable). You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at (insert website address, if applicable).

III. HOW I MAY USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

2. To Obtain Payment for Treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3. For Health Care Operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

4. Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.
2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.
3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.
4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.
5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.
6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.
7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.
8. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to Family, Friends, or Others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Restrictions on My Uses and Disclosures. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

B. The Right to Choose How I Send PHI to You. You have the right to request that I send confidential information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Receive a Copy of Your PHI. In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than \$.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Receive a List of the Disclosures I Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003. I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to

file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

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V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may 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. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at:

16870 West Bernardo Drive, Suite 400, San Diego, CA 92127 * 619-687-9013.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.