

JAN WILLER, Ph.D.
LICENSED CLINICAL PSYCHOLOGIST
2334 W. LAWRENCE AVE, SUITE 212, CHICAGO, IL, 60625
773-859-1822

Welcome, and I am looking forward to seeing you for your first session. In order to be clear about our expectations of each other, I have compiled the following practice policies. Please look them over and let me know if you have any questions or comments about them.

Practice Policies

1. All sessions are 45-50 minutes. Please come on time. Due to the scheduling of others' appointments, I am usually unable to extend past the usual end time. Your full fee will be due even if you are late.
2. However, if I am running late, I will either prorate your session fee (if possible, given your payment situation) or extend the time.
3. Fees or copayments are due at the time of the appointment. You may make out a check beforehand if you want to save time during the session.
4. Insurance issues: if you expect another payer (e.g. insurance, Medicare) to be paying for part of your session, it is your responsibility to ensure that you are covered by that payer. You will be charged if the other payer does not pay your bill as you expected.
5. I check my messages at least once each day. I will attempt to return any message you leave for me within 24 hours of getting it. Routine messages left on Saturday or Sunday will be returned on Monday. I am not available by phone after 7 pm or before 9 am.
6. If you are having an emergency and I am not available at that time, you may call a hotline. If it may be a life-threatening emergency, do not call me first. Instead, call 911 or go to your nearest hospital emergency room.
7. There will be a charge for lengthy phone consultations.
8. If any of these policies do not work for you, please let me know; I will attempt to refer you to someone who may be able to meet your needs better.

If you would like to contact me by e-mail:

1. Please feel free to communicate with me by e-mail. My e-mail address is jan@drwiller.com. I typically check my e-mail every 1-4 days, so if your matter needs more timely attention, please call instead.
2. Do not e-mail me in an emergency. Call instead.
3. I will do the best I can to assure your confidentiality through e-mail, but due to viruses, hackers, etc, no e-mail correspondence can be guaranteed to be confidential. So do not send any information that you would consider to be sensitive information through e-mail.

My signature below shows that I understand and agree to comply with the above practice policies.

Signature of client

Date

Printed name

Please give me a copy and keep a copy of this handout for your reference.

CHECKLIST OF CONCERNS

Name: _____ Date: _____

Please mark any items that apply to you. Feel free to add other concerns at the bottom.

I have no problem or concern bringing me here

PROBLEM AREAS--CAREER, SCHOOL

- Career concerns, goals, and choices
- Unemployment
- Job stress
- School problems
- Learning problems
- Work performance issues such as procrastination,
- Work life balance issues, e.g. workaholism/overworking
- Difficulty maintaining employment

PROBLEM AREAS--RELATIONSHIPS

- Communication problems
- Dating issues
- Detachment or estrangement from others
- Divorce, separation
- Friendships
- Infidelity, affairs
- Interpersonal conflicts
- Parenting issues
- Sexual issues with partner
- Social problems
- Physical fights with relationship partner
- Physical fights with others
- Relationship conflict
- Relationship problems
- Withdrawal, isolating

PROBLEM AREAS--LIFE EVENTS

- Childhood issues (your own childhood)
- Financial or money troubles, debt, impulsive spending, low income
- Grieving, mourning, deaths, losses
- Legal matters, charges, suits
- Other (Please specify: _____)

PROBLEM AREAS--PHYSICAL WELL-BEING

- Headaches, neck or back pain (Please specify: _____)
- Health, illness, medical concerns, physical problems
- Menstrual problems, PMS
- Pains, chronic (Please specify: _____)
- Sexual functioning problem (e.g. erectile dysfunction, painful intercourse)

PROBLEM AREAS--SELF

- Identity issues
- Sexual identity issues
- Suicidal ideas
- Thoughts that life may not be worth living
- Self-esteem problems

EMOTIONAL CONCERNS

- Alert for danger, even in safe locations
- Anger, hostility
- Distressing memories of the past
- Suspiciousness
- Anxiety, nervousness
- Aggitated
- Fear of leaving my home
- Fear of specific locations, such as elevators or planes (Please specify: _____)
- Fear of specific situations, such as heights or snakes (Please specify: _____)
- Fear of social situations
- Fear of abandonment
- Obsessive thoughts
- Panic or anxiety attacks
- Feeling hyper or wound up
- Phobias (Please specify: _____)
- Shyness
- Tension—can't relax
- Attention, concentration, are poor
- Confusion
- Distractibility
- Memory problems
- Loneliness
- Depression, low mood, sadness, crying
- More depressed in the morning, with mood better later in the day
- More depressed in the winter, mood better in the summer
- Emptiness feelings
- Failure feelings
- Fatigue, tiredness, low energy
- Guilt
- Inferiority feelings
- Motivation problems
- Oversensitivity to rejection
- Oversensitivity to criticism
- Lack of interest in my usual activities
- Hopelessness
- Mood swings
- Overly high energy level for my age
- Perfectionism
- Sexual drive—lack of
- Feeling that others are out to get me
- Feeling that others are watching me
- Hearing voices

BEHAVIORAL ISSUES

- I drink alcohol more than 2 nights per week
- At least one day a week, I have 4 drinks or more (if female) or 5 drinks or more (if male)
- I have used an illegal drug in the last month
- I smoke at least one cigarette per week
- At least once a week, I drink more than 2 cups of coffee, OR more than 4 colas or cups of tea

- I have had a DUI (When? _____)
- I have been charged with a crime in the past (other than parking, speeding or DUI)
- Aggressive or violent thoughts or behaviors
- Arguing
- Compulsive behaviors (Please specify: _____)
- Repetitive behaviors (e.g handwashing, checking doors, checking stove)
- Cutting or otherwise injuring self
- Other self-harm in past (Describe: _____)
- Decision making problems, indecision, mixed feelings, putting off decisions
- Disorganization
- Gambling
- Irritability
- Impulsiveness
- Irresponsibility
- Judgment problems, risk taking
- Self-neglect, poor self-care
- Suicide attempt in past (When? _____)
- Temper problems, self-control, low frustration tolerance

EATING/WEIGHT ISSUES

- Lack of appetite
- Weight loss (How much? _____ Over what time? _____)
- Overeating
- Weight gain (How much? _____ Over what time? _____)
- Vomiting
- Taking laxatives, enemas or diuretics to lose weight
- Binging on food
- Diet issues
- Fear of becoming fat

SLEEP ISSUES

- Sleeping too much
- Insomnia
- Difficulty going back to sleep upon awakening during night
- Too much worrying or thinking keeps me from getting to sleep
- Waking at least 2 hours too early in the morning
- Feeling extremely restless or squirmy prior to bedtime
- I have taken a sleeping pill or drank alcohol to sleep at least once in the past month
- Nightmares or upsetting dreams
- Suddenly falling asleep in inappropriate locations
- Snoring
- Grinding teeth during sleep
- Stopping breathing briefly during sleep (noticed by you OR partner)
- Sleepwalking

ANY OTHER CONCERNS OR ISSUES:

WHICH CONCERN DO YOU MOST WANT HELP WITH?

CLIENT INFORMATION FORM

TODAY'S DATE _____

GENERAL INFORMATION

Your full name (Last, First, Middle Initial) _____

Date of birth _____ Age _____ Social Security # _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

I need to send mail to clients occasionally. If you have any problems with this, please let me know. If this is ok, please initial here: _____

Home/evening phone _____ Cell phone _____

Calls will be discreet, but please indicate any restrictions _____

e-mail address _____

I need to send e-mail to clients occasionally. If you have any problems with this, please let me know. If this is ok, please initial here: _____

Does anyone live in your home with you? What is (are) the relationship(s) to you?

How were you referred to my office? _____

Who may we thank for referring you? _____

MEDICAL CARE*

Physician _____ Phone _____

Address _____

**At your request, I would be happy to give your primary care physician a very brief summary of your mental health diagnosis and status. Many people like their primary care physician to be updated on all of their health care. If you would like me to assist you in this way, please sign a Release of Information form and supply your physician's name.*

EMPLOYER

Name of Employer _____ Work phone _____

Calls will be discreet, but please indicate any restrictions _____

YOUR CURRENT CONCERNS

Please describe the main difficulty that has brought you to see me

PSYCHOTROPIC MEDICATIONS

_____ I do not take psychotropic medications

Psychiatrist _____ Phone _____

Address _____

If you enter treatment with me for psychological problems, I strongly recommend that treatment be coordinated between your psychiatrist and me. Do you have any problems with this? ___ No ___ Yes

EDUCATION AND TRAINING

Did you graduate from HIGH SCHOOL? ___ Yes ___ No

Year of graduation _____

COLLEGE OR VOCATIONAL SCHOOL Attendance and Degrees/Certificates:

From	To	School	Degree Program	Did you graduate?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EMPLOYMENT AND MILITARY ENLISTMENT for the last 2 years

Dates		Name of military or employers	Job title or duties	Reason for leaving
From	To			
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

HISTORY OF EVENTS

Please indicate any of the following events that may have occurred to you in the past:

- ___ My parents/caretakers punished me physically as a child or teenager
- ___ My parents/caretakers were verbally harsh and critical of me as a child or teenager
- ___ My parents/caretakers did not provide appropriate supervision, food, shelter or other protection.
- ___ My parents/caretakers were unaware of my difficulties when I was a child or teenager.
- ___ I experienced inappropriate sexual contact as a child or teenager
- ___ I experienced sexual harassment as an adult
- ___ I experienced other upsetting sexual experience(s) as an adult
- ___ As an adult, I experienced a physical injury intentionally caused by another adult.
- ___ I experienced any other upsetting experience(s) as noted below:

PRESENT RELATIONSHIP

___ I do not have a partner at present
 How would you characterize your relationship with your partner? _____

USE OF CAFFEINE, ALCOHOL, TOBACCO AND STREET DRUGS

How much coffee, cola, tea, or other sources of caffeine do you consume each day?

- 1. Have you ever felt the need to cut down on your drinking? ___ No ___ Yes
- 2. Have you ever felt annoyed by criticism of your drinking? ___ No ___ Yes
- 3. Have you ever felt guilty about your drinking? ___ No ___ Yes
- 4. Have you ever taken a morning "eye-opener"? ___ No ___ Yes
- 5. How much beer, wine, or hard liquor do you consume each week, on the average?

6. How much tobacco do you smoke or chew each week?

7. Which street drugs have you used in the last 3 years?

LEGAL ISSUES

1. Are you presently suing anyone or thinking of suing anyone? ___ No ___ Yes
 If yes, please explain:

2. Is your reason for coming to see me related to an accident or injury? ___ No ___ Yes
 If yes, please explain:

3. Are you required by a court, the police, or a probation/parole officer to have this appointment?
 ___ No ___ Yes If yes, please explain

4. Have you had any contacts with the police, courts, and jails/prisons regarding a crime that you were charged with? No Yes
5. Are there any other legal involvements I should know about? No Yes
- If yes, pls describe:
-

MEDICAL HISTORY

1. Please list all CURRENT MEDICAL PROBLEMS that you have. Be sure to include chronic conditions such as asthma, seizure disorder, arthritis, diabetes and so on

2. Please rate your current level of PHYSICAL PAIN on a scale of 0-10, with 0 being no pain and 10 being the worse pain you have ever had _____
 Rate the most severe pain you have had in the past month _____
 Why were you experiencing pain? _____

3. List all MEDICATIONS, HERBAL SUPPLEMENTS, VITAMINS, AND OVER-THE-COUNTER DRUGS you have taken in the last month.

Medication/drug	Dose (how much?)	Taken for	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HEALTH HABITS

1. What kinds of physical exercise do you get?

2. How many times per week do you typically exercise for 20 minutes or more? _____
3. Do you try to restrict your eating in any way? How? Why?

4. What is your average number of hours of sleep per night? _____

CONTACT PERSON IN CASE OF EMERGENCY

Name: _____

Address: _____

Phone: _____ Relationship to you: _____

INFORMATION CHECKLIST

Please review the following list of treatments you may have had in the past. Please put a check next to any that apply to you and indicate the dates, to the best of your recollection.

	___	No	___	Yes	Dates:
Inpatient psychiatric hospitalization					_____
Intensive outpatient treatment (e.g. at least 2-3 days per week)					_____
Psychotherapy					_____
Outpatient Substance Abuse counseling					_____
Attending AA/NA/CA meetings					_____
Taking medication for emotional difficulty					_____
Taking medication for sleep					_____

NOTE: PLEASE FILL OUT A RELEASE OF INFORMATION FORM FOR ANY MENTAL HEALTH PRACTITIONER OR PROGRAM YOU HAVE BEEN TREATED BY DURING THE LAST 2 YEARS. ALSO, PLEASE FILL OUT A FORM FOR ANY PHYSICIAN WHO HAS GIVEN YOU PSYCHOTROPIC MEDICATIONS WITHIN THE LAST 2 YEARS.

CANCELLATION AND NO-SHOW POLICY

PLEASE READ CAREFULLY!

If you need to cancel, please call at least 48 hours ahead.

Cancellation fees are as follows:

- 48 hours or more: No fee
- Less than 48 hours: \$100 fee
- If you do not show up for your appointment and do not call, there is a \$100 fee as well.

SPECIAL CIRCUMSTANCES

- **If you have a crisis and can't attend your appointment, call me and we will talk about it.**

My signature below shows that I understand and agree to comply with the cancellation policy.

Signature of client

Date

Printed name

Please turn this page in and keep a copy of this page for your reference.

Confidentiality Information

I will treat what you tell me with great care. My professional ethics (that is, my profession's rules about moral matters) and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about—in other words, the “confidentiality” of therapy. But I cannot promise that everything you tell me will *never* be revealed to someone else. There are some times when the law requires me to tell things to others. There are also some other limits on our confidentiality. Because I want you to understand clearly what I can and cannot keep confidential I have prepared this handout. These are very important issues, so please read these pages carefully and keep a copy. We can discuss any questions you might have.

1. Insurance

If you use your health insurance to pay a part of my fees, insurance companies require some information about our therapy. Insurers such as Blue Cross/Blue Shield or managed care organizations may ask for information about you and your symptoms, as well as a detailed treatment plan. Please understand that I have no control over how these records are handled at the insurance company. My policy is to provide only as much information as the insurance company will need to pay your benefits.

2. Legal Limitations to Confidentiality

You have the right to keep what you tell me private. Generally, no one will learn of our work without your written permission. There are some situations in which I am required by law to reveal some of the things you tell me, even without your permission. Here are some of these situations:

- a. If I come to believe that you are threatening serious harm to another person, I am required to try to protect that person. I may have to tell the person and the police, or perhaps try to have you put in a hospital.
- b. If you seriously threaten or act in a way that is very likely to harm yourself, I may have to seek a hospital for you, or to call on your family members or others who can help protect you. If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very strong reason not to.
- c. In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life. I will try to get your permission first, and I will discuss this with you as soon as possible afterwards.
- d. If I believe or suspect that you are abusing a child or an elderly person, I must file a report with a state agency. To “abuse” means to neglect, hurt, or sexually molest another person. I do not have any legal power to investigate the situation to find out all the facts. The state agency will investigate. If this might be your situation, we should discuss the legal aspects in detail before you tell me anything about these topics. You may also want to talk to your lawyer.
- e. If a court orders me to testify about you, I must do so.
- f. If I am testing or treating you under a court order, I must report my findings to the court.

3. Sending Your Records Out

If you want me to send information about our therapy to someone else, you must sign a “release-of-information” form. I have copies that you can see, so you will know what is involved. If your records need to be seen by another professional, or anyone else, I will discuss it with you. If you agree to share these records, you will need to sign a release form. This form states exactly what information is to be shared, with whom, and why, and it also sets time limits. You may read this form at any time. If you have questions, please ask me.

4. Professional Consultation

I sometimes consult other therapists or other professionals about my clients. This helps me in giving high-quality treatment. These persons are also required to keep your information private. Your name will never be given to them, and they will be told only as much as they need to know to understand your situation.

5. Back-Up Therapeutic Coverage

When I am away from the office for a few days, I have a trusted fellow therapist “cover” for me. This therapist will be available to you in emergencies. Therefore, he or she may need to know about you. Of course, this therapist is bound by the same laws and rules as I am to protect your confidentiality.

6. Professional Educational Use of Case Materials

As a therapist, I naturally want to know more about how therapy helps people. I would be grateful for your consent to use your case material in my other professional activities. Your material may help in the development of the mental health field or in the training of health care workers. It is possible that I could use your material in teaching, supervision, consultation with other therapists, publishing, or scientific research. For these purposes, I would use clinical or case notes that I have taken during or after our sessions. You would not get any financial benefit from this. When I use information from my therapy work, I do not want anyone who hears, reads, or sees it to be able to identify the clients involved. Therefore, I conceal your identity by removing or changing all identifying information. In particular, I would not use your real name, or even a detailed description of you, in any presentation, article or book. If you do not agree to the uses of case materials as indicated, you will not be penalized in any way, and it will not affect the care you receive in any way. You may draw an X through this section and initial it if you do not want your case materials used in this way.

7. Legal Consultation

The laws and rules on confidentiality are complicated. Please bear in mind that I am not able to give you legal advice. Are you suing someone or being sued? Are you being charged with a crime? If so, and you tell the court that you are seeing me, I may then be ordered to show the court my records. If you have special or unusual concerns, such as these, and so need special advice, I strongly suggest that you talk to a lawyer about these concerns.

I give the therapist named below my permission to use case materials for research, teaching, writing and advancing other professional purposes. I understand that they will be used as an aid in the process of improving mental health work or training health care workers. These professionals and their students are bound by state laws and by professional rules about clients' privacy.

My signature below shows that I understand all of the above information about confidentiality.

Signature of client

Date

Printed name

I, the therapist, have provided an opportunity for the client to ask any questions about confidentiality. My observations of this person's behavior and responses indicate that this person is fully competent to give informed and willing consent.

Signature of therapist

Date

Please keep a copy of this handout for your reference.

<p>PLEASE KEEP THIS FORM FOR YOUR REFERENCE AND RETURN THE SIGNATURE PAGE TO DR WILLER</p> <p>Jan Willer, Ph.D.</p>	
<p>EFFECTIVE DATE: April 14, 2003</p>	<p>NOTICE OF PRIVACY PRACTICES FORM REFERENCED POLICY:NOTICE of PRIVACY PRACTICES</p>

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

Every visit to a physician, psychologist or other healthcare provider creates a record that is kept electronically or in paper form. This record typically includes symptoms, examination notes, diagnoses, test results, and plans of treatment. This Notice of Privacy Practices applies to all of the records of your protected health information produced or maintained by this Practice.

This Practice is required by law to maintain the privacy of protected health information, give each patient our Notice of Privacy Practices, and follow the practices listed below. Additionally, I am required to revise this Notice of Privacy Practices if the law or my privacy practices change, and provide an internal complaint process for privacy issues.

This Notice of Privacy Practices relates to the organizations listed below and the locations they maintain for providing health care services and products.

Jan Willer, Ph.D.
 2334 W. Lawrence Ave
 Suite 212
 Chicago, IL 60625

REVISIONS TO THE NOTICES OF PRIVACY PRACTICES

This Notice of Privacy Practices applies to all mental health records containing your protected health information that is produced or maintained by or on behalf of this Practice. I reserve the right to change these policies at any time. Changes will apply to information about you that I already have as well as any new information after the change takes place. Before I implement significant changes in these policies or privacy practices, I will post a new notice. You are entitled to this Notice at any time upon request. You will be asked to acknowledge in writing your receipt of this Notice.

QUESTIONS and COMPLAINTS

If you have any questions about this Notice of Privacy Practices, please contact me using the information listed below. If you believe the privacy rights related to your protected health information have been violated you have the right to file a complaint with the individual listed above. You also may submit a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Officer will provide you the address upon request.

I support your right to protect the privacy of your medical information. I will not retaliate in any way if you choose to file a complaint with me or with the U.S. Department of Health and Human Services.

USES and DISCLOSURES OF HEALTH INFORMATION

This Practice may use and disclose medical information about you for several different purposes. Below find an example of each possible use or disclosure of your protected health information.

Appointment Reminders: This Practice may use or disclose your protected health information to remind you that you have an appointment for healthcare services. Reminders may include written notifications distributed via the US Postal system, verbal telephone communications and/or messages, or electronic mail messages.

Treatment: This Practice may use or disclose your protected health information to treat your medical condition. For example, I may ask you to submit yourself to a laboratory test or psychological testing, and I may use the results to obtain a diagnosis. Additionally, I may disclose your medical information to other members of a staff team participating in delivering services to you. This practice may also call patient names in the office waiting room.

Payment: This Practice may use and disclose your protected health information in order to bill and collect payment for the healthcare services provided to you from this office. For example, I may provide information to make contact with your health plan to verify your enrollment and your eligibility for benefits.

FURTHER SITUATIONS WHICH HEALTH INFORMATION MAY BE USED and DISCLOSED

Required by Law. This Practice may use or disclose medical information about you when required by law. This office is required by Federal law to disclose your protected health information to the U.S. Department of Health and Human Service upon request for purpose of determining whether this medical practice is in compliance with the Federal Privacy Standards. Also, if I receive a court order requiring me to provide information, I will comply with the order to the extent required by law.

This Medical Practice will not use or disclose protected health information in any manner that would violate the following laws:

- Illinois Nursing Home Care Act
- Illinois Mental Health and Development Disabilities Confidentiality Act
- Illinois Mental Health and Development Disabilities Code
- Illinois Medical Practice Act
- Illinois Aids Confidentiality Act
- Illinois Medical Patient Rights Act
- Illinois Genetic Testing Act
- Federal Drug Abuse, Prevention, Treatment and Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970

Law Enforcement: Under some circumstances, this Practice may disclose health information if a request is made by law enforcement officials. For example:

- In connection to criminal conduct at this office;
- In an emergency situation, to report a crime, victims of a crime, and the description, location, or identity of the perpetrator;
- To identify a suspect, material witness, fugitive or missing person, to the extent required by law;
- Concerning a death believed to be the result of criminal activity; and
- Regarding a crime victim in certain situations.

Public Health Activities: This Practice may disclose your health information for public health activities, including:

- To report child abuse or neglect, or abuse or neglect of a patient in a long term care facility (including a mental health facility);
- To maintain vital records, such as births and deaths;
- To report side-effects to drugs or defects with products or devices;
- To comply with reporting laws concerning communicable disease (but such a report would be done without revealing that you are receiving mental health services);

- To alert individuals if a product or device they have has been recalled.

Serious Threats to Health or Safety: This Practice may use or disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of others. Under this situation, this office will only disclose health information to an agency or authority able to help prevent the threat.

Specialized Government Functions: I may disclose your health information to federal officials for intelligence and national security activities required by law. Additionally, this office may disclose your health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement officials.

PATIENT RIGHTS REGARDING HEALTH INFORMATION

Right to Request Restrictions: You have the right to request a restriction on the use and disclosure of your protected health information for purposes of treatment, payment, and health care operations. I am not required to grant any such request for restriction, but if the restrictions are granted they will be legally binding, except in certain circumstances. You must fill out a Health Information Restriction Request Form in order to make the restriction valid.

Right to Provide an Authorization for Uses and Disclosures: You have the right to give authorization for uses and disclosures that are not identified by this Notice of Privacy Practices or are not permitted by applicable law. The authorization will be obtained by you completing the Authorization for Other Uses and Disclosures Form. Any authorization may be revoked at any time in writing. Once an authorization has been revoked, this Practice may not use or disclose your health information for the purposes detailed in the authorization.

Right to Confidential Communications: You have the right to request that this Practice communicate with you by an alternate means or at an alternate location. For example, you may ask us to contact you by e-mail rather than by phone or traditional mail. This practice will accommodate reasonable requests. To submit a request for confidential communications, please complete a Confidential Communication Request Form.

Right to a Paper Copy of the Notice of Privacy Practices: You have the right to a paper copy of the Notice of Privacy Practices. You may ask this Practice to give you a copy at any time. If you first obtain the Notice of Privacy Practices electronically, you may still request this office send you a paper copy.

I have received a copy of the Notice of Privacy Practices (NPP):

Printed Name

Signature of Individual Acknowledging NPP

Place keep a copy for your reference and return this signature page to Dr Willer for placement in your chart.