Thomas D. Carver, MA, LMFT
Licensed Marriage and Family Therapist
The Sespe Counseling Center and Gallery
155 Granada Street, Suite O, Camarillo CA 93010
PH. (805) 794-7800 thomas@thomascarver.com
www.thomascarver.com

Thomas Carver is focused on helping people explore their personal journey through life's challenging transitions. He assists individuals and couples in uncovering unconscious patterns, which keep them from realizing their full potential. His practice includes work that fosters discovery of innate strengths in relationships and new communication skills so that they can express their deepest needs to loved ones. He believes in the four keys to wellness: mind, heart, body, and spirit and uses them to frame deep, introspective healing.

Thomas is certified in the marital modalities of John Gottman Therapy (Level III+) and uses Emotionally Focussed Therapy (EFT). He is certified in trauma protocols including Eye Movement Desensitization and Reprocessing (EMDR) (Levels I & II+) and Developmental Needs Meeting Strategy (DNMS) used in the treatment of trauma including family of origin trauma/dysfunction and survivor of physical, sexual, and/or emotional abuse, etc. He also has extensive experience in Parenting/Adolescent Therapy.

Mr. Carver uses a multi-modal approach including (primarily) the theories of Family Systems, Psychodynamics, Solution Focused, Ego State, and Cognitive/Dialectic Behavioral Therapies (CBT/DBT). His practice is rooted in promoting nondenominational spiritual perspectives.

Additionally, he specializes in Co-Parenting/Divorce Dynamics and Parent Alienation and is a Therapeutic Assisted Divorce Mediator in partnership with an attorney. He uses a solution-focused, Child Centered/Two-Home Family Model (Parallel Parenting transitioning into Co-Parenting) for mediating high conflict divorcing couples. He has experience as a court appointed Reunification Therapist and Co-Parenting Therapist and Special Master/Parenting Plan Coordinator.

Please see his web page for additional specialities at www.thomascarver.com

INTAKE INFORMATION

Please be sure to legibly fill out the Intake Information page completely including your address, date of birth, social security number, home and cell phone numbers, email, and signature(s). It is important that I know if you are on any medications and who the prescribing physician(s) are.

Date: _____

CLIENT: _____ Birth Date: _____

Address: _____ Gender: _____

_____ SSN: _____

_____ Home Phone: _____

Work Phone: _____ Cell Phone : _____

Client's Occupation: _____ Email: _____

Relationship Status (circle): Single Married Domestic Partner Divorced Other _____

Employer or School: _____

Address: _____

Who referred you? _____

Physician: _____ Physician's ph: _____

Date of last physical: _____

Major Illness: _____

Current Medications: _____

Previous Psychotherapy? Yes No

If yes, when? _____ With whom? _____

Psychiatrist _____ With whom? _____

If yes, when? _____

Diagnosis(es) _____

OTHER FAMILY MEMBERS:

Name:	Birth Date	Relationship:	Living at Home?
_____	_____	_____	yes / no
_____	_____	_____	yes / no
_____	_____	_____	yes / no
_____	_____	_____	yes / no
_____	_____	_____	yes / no
_____	_____	_____	yes / no

PERSON RESPONSIBLE FOR THE ACCOUNT: _____

Address (*if different from above)*: _____

Client signature: _____ Date: _____

Client signature: _____ Date: _____

I AUTHORIZE TREATMENT FOR THE MINOR CHILD(REN) UNDER MY CARE.

Signature: _____ Date: _____
(parent or legal guardian)

Signature: _____ Date: _____
(parent or legal guardian)

INSURED/INSURANCE INFORMATION

(Please provide a copy or photo of the front and back of insurance cards)

PRIMARY INSURANCE:_____

Insured name: _____ Gender: _____

Address: _____ Date of Birth: _____

_____

Policy #: _____ Group #: _____

Relationship to client (circle): Self Spouse Other _____

Contact Number to receive benefit information: _____

SECONDARY INSURANCE: _____

Insured name: _____ Gender: _____

Address: _____ Date of Birth: _____

_____

Policy #: _____ Group #: _____

Relationship to client (circle): Self Spouse Other _____

Contact Number to receive benefit information: _____

Please note: **All charges are your responsibility. It is your responsibility to maintain insurance coverage, update me of any changes, and verify PPO ONLY benefits as well as obtain information as to deductibles, insured billable rate, percent reimbursable, and (n/a) co-payment for ensuring reimbursement if you have PPO out-of-network benefits. Please present card at first appointment or email/text a copy. We require an image of the front and backside of the card and your date of birth. Otherwise therapy is a on a cash-pay basis.**

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process claims and I authorize payment of medical benefits to the undersigned physician or supplier for services described on claims.

Client signature: _____ Date: _____

Client signature: _____ Date: _____

EXCEPTIONS TO CONFIDENTIALITY

Confidentiality is the cornerstone of therapy. What you say to me is held in the utmost confidence. It is my job not only legally, but ethically to protect your privacy. If someone were to contact me and ask if I am seeing you, I will clearly state that I can not discuss any case with a third party and that I cannot avow or disavow that I even knowing you. Also, if I see you in public, I will not initiate contact. However, under certain legally defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:

A. Revealing to me active child abuse or neglect if a perpertrator is in contact with a minor and there is a reasonable suspicion that they may still be abusing minors. Also if active physical abuse of a dependent adult or an elder is taking place. I am required to report any suspected child or elder abuse (either current or past) to local child protective or law enforcement officials within 24 hours. Abuse is defined as the willful cruelty to or the unjustifiable punishment of a child or elder person or endangering the life or health of either one (Section 11161.5 - Cal. Penal Code). This includes sexual molestation, the willful infliction of physical pain or injury, willfully causing or permitting unjustifiable mental suffering or the willful failure to provide necessary food, clothes, shelter, and medical attention. If any therapist fails to report, they may be both civilly and criminally liable (Section 273a - Cal. Penal Code)

B. If you seriously threaten harm or death to another person. I am required to warn the intended victim and notify the appropriate law enforcement agencies.

C. If I believe that you truly intend to do harm to yourself, I will make every effort to ensure your safety. If I am unable to do this, then the law requires that I must notify the police.

D. If you are in therapy or are being evaluated by order of the court. The results of that assessment, treatment and conclusions are revealed to that court. I am sometimes required to create documents (ie Co-Parenting Plans, Reunification Plans, Progress Reports etc.).

E. If you are using your insurance to pay some of all of your therapy costs, it is important for you to know that I am sometimes required to make reports to the insurance company regarding your diagnosis and course of treatment. I may also use electronic methods to communicate with your insurance company.

F. In the arena of Divorce Assisted Mediation confidentiality changes in that I may be called as a witness by either party (post marital therapy) and the laws regulating subpoenas come into play. It is my office policy when a case changes (i.e.) from marital therapy, to a private mediation and might devolve into a litigated divorce and/or beyond into the possibility of individual therapy occuring, confidentiality is waived regarding information that was obtained before, during and after the mediation; unless protected under the laws of privilege to be determined by a Judge. See the section Unit of Therapy/Scope Changes for a clearer understanding of these circumstances. Individual therapy confidentiality is not waived.

Client signature: _____ Date: _____

Client signature: _____ Date: _____

OFFICE POLICIES HIGHLIGHTS PAGE

Session Rates: **Please pay at the beginning of each session**
The initial intake/assessment session fee is **$150.00** per 50 minutes. The following sessions are charged at a standard rate of **$145.00** per 50 minutes. For court-involved cases the hourly rate is **$170.00** per 50 minutes and if I am appointed to fulfill a specific role for the courts (i.e. Special Master/Parenting Plan Coordinator, etc.) a **$5000** retainer is held and replenished when dropped below $2500. Any portion of the retainer not used is returned within 30 days at the conclusion of therapy. For writing any documents I charge **$145** per page/hour. Payments can be paid by check or cash or by Zelle or Venmo (Please see attached QR Codes). A $25.00 late fee is automatically added to overdue accounts for each month they remain delinquent. Our office will bill you for three months before utilizing a collection agency for unpaid charges.

Insurance Payments/Reimbursement:
I am not a contracted provider for any insurance company. But for clients who have PPO out of network benefits I am able to submit (as a courtesy) sessions to your insurance company so that you can get reimbursed and/or have your payments for therapy count towards your deductible. It is important that you provide me a copy of the front and back of your insurance card. I also need the name and date of birth of the person who is insured for billing. While we can check into insurance benefits for you, ultimately you are responsible for knowing what benefits you have. You can expect to have bills submitted to your insurance company about once a month.

Cancellations:
If you need to cancel a session, please remember I require 24 hour notice. You can leave a message on my voicemail or text message (preferred) 24 hours a day, 7 days a week (805-794-7800) or by email (thomas@thomascarver.com). **If you fail to contact me within 24 hours of your session, you will be charged the full fee of $145.00 for your missed session (charged to you, not your insurance company - they do not pay for "no shows")**. If we have a set recurring appointment, you will be charged for the duration of two more scheduled appointments without contact to cancel those appointments (see Termination section).

Telephone/e-mails/texts:
Telephone/email time outside of our scheduled sessions is limited to 10 minutes, beyond which I will bill you at my sandart rate rounded to the next half hour. Payment will be expected at the next regularly scheduled appointment, or sooner by mail or venmo.

Treatment of Minors:
Children under the age of 18 years must have the consent of all parents/guardians who hold "legal custody." I will not treat children without this written consent. I prefer to involve all parents/guardians as much as is therapeutically appropriate. I will be glad to discuss how, when, and if this can be accomplished in your case. Additionally in court referred cases, I need copies of all court documentation.

Individual Sessions in the Course of (i.e.) Marital/Family Therapy
It is usual and customary for me to pace sessions with multiple people with interspersed (or otherwise agreed upon) individual sessions with participants and adjunctive individuals, such as other concerned parties who play critical roles in me understanding complicated dynamics. Each person in these sessions has confidentiality, but if issues are discovered that we find are pivotal to therapeutic process of the couple/group I will attempt to agree with that person on a strategy that they can disclose that information themselves. If they do not, at a future individual session, we will process 'what do they need to succeed' in divulging said information, but ultimately it is their decision. However, if that block continues to cause a serious breakdown in the resolution of therapy goals, it may be a reason for terminating the case if I simply cannot be further helpful without that information.

Unit of Therapy & Scope Changes: i.e. Divorce Assisted Mediation:
The Unit of Therapy is the persons or people that are specifically named as clients in a case. Because I provide a wide range of therapies, during the course of therapy my role can change, such as starting a

case as a marital therapist that may result in the couple declaring they cannot remain married. As a courtesy, because we may have worked over a long period of time and because I am also a Divorce Assisted Mediator, the couple may request that I perform the actual co-facilitated divorce/mediation or the coordination of that mediation because they do not want the case to start over with a new Therapist. They may need the enhanced support to get through a tough mediation and keep the case out of the Family Courts if at all possible. This is not a change in the Unit of Therapy, therefore not requiring more than a documented method of informing the couple (etc.) that the scope has changed (i.e. via letter, email and/or text). The Scope of Work, defined as the direct psychotherapy treatment, performing client psychosocial assessments, developing treatment plans and guiding the treatment process, developing exit plans, providing psychological and emotional support to clients, and in the case of Divorce/Mediation resolving the issues with different degrees of involvement of consultants such as an Attorney, Accountant, etc. This includes, but is not limited to, division of assets, child/spousal support, child custody and visitation, and other specific issues to that group/couple that require conflict resolution in tandem with the aforementioned professionals to complete, I do not give legal advice and simply consult with regard to concerns that require focus when engaging in mediation. Couples are required to either use an attorney, LDA, or themselves to file court documents.

Additionally, some cases when marital therapy is terminated or the case went to mediation and moved to litigation, and the configuration of the case has been terminated between the Unit(s) of Therapy, one of the couple/parties may request to transition into individual therapy, again because they do not wish to start over with another Therapist. If this request is made I will refer the other party (parties) to a qualified Therapist(s). This does not require mutual consent. It is determined by my assessment of who will best benefit from my services and who may need a new Therapist. I can consult with that new Therapist to help facilitate a dynamic transition and ongoing conflict resolution. This is done with a Release of Information Contract signed by all involved parties (in the Unit of Therapy, etc.).

Exceptions to Confidentiality:
Review thoroughly in the attached Therapeutic Contract/Informed Consent for Treatment in the section called Limits to Confidentiality.

Court Involved Cases:
Please provide me with a copy of <u>all</u> court documentation (ie: Divorce Decrees, Restraining Orders, etc.)

I have read the attached **Therapeutic Contract/Informed Consent for Treatment** and fully understand this Office Policies Highlights Page and Exceptions to Confidentiality Page.

Client signature: _____ Date: _____

Client signature: _____ Date: _____

THERAPEUTIC CONTRACT/INFORMED CONSENT FOR TREATMENT

The Therapy Process:

Participating in therapy can result in a number of benefits to you including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working towards these benefits, however, requires effort on your part and may result in your experience in considerable discomfort / change that will sometimes be easy and Swift but more often it will be slow and frustrating. Remembering and resolving significant life events in therapy can bring on strong feelings of anger, depression, fear, Etc. Attempting to resolve issues between marital Partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended, as part of the therapeutic process.

Releases of Information:

If you want me to discuss any part or all of your treatment with anybody, I must have a Release of Information Contract to do so. These are used primarily for the purposes of consultation, case management, and other collaborative efforts that I engage in for your benefit. I can only talk to someone else about your case with your permission considering the above limits to confidentiality. If you ask me, I can release any part of your records on file to any person you specified. I cannot give legal advice.

Client's Rights Regarding Their File:

1. You have the right to ask questions about any of the procedures used in the course of your therapy.

2. You have the right to see the content of your records at any time and I have the right to provide you with a summary of their content and a complete copy of records if necessary. I can refuse to produce the file or it's content if I assess that the information will cause harm (ie: to a child).

Termination:

You have the right to terminate therapy with me at any time without any Financial, legal, or moral obligations other than those you've already incurred. I have the right to determine 8 therapy with you under the following conditions:

1. When I believe that therapy is no longer beneficial to you.
2. When I believe that you will be better served by another professional.
3. When you have not paid for the last three sessions, unless special arrangements have been made with me.
4. Clients are assumed to be in my weekly/biweekly schedule rotation. When clients do not show for three therapy sessions in a row without 24-hour notice by phone or email (NOT by text message) they are considered terminated unless otherwise communicated. Clients maintaining contact with me indicates they are interested in remaining in my schedule rotation. **Clients are financially responsible for no show appointments.**
5. If at any time I determine that I cannot help you, I will assist you in finding someone qualified. If I have written consent, I will provide that professional with information to assist with the transition.
6. In all cases I will be happy to provide you with the resources and referrals as necessary.

Cancellation:

Since an appointment reserves time specifically for you, a minimum of twenty-four hours notice is required for the rescheduling or cancellation of an appointment. The full fee will be charged for missed

sessions without such notification. Insurance companies ***do not*** reimburse for sessions missed. As a courtesy, if a client misses a session, payment is due that day, but if I am able to get you in on a waiting list between the time of the next session (I.e. that week) that spot will be at no charge as a make-up session. This is difficult to do, but can be arranged.

Telephone/Email time:

After 10 minutes of telephone time, you will be charged at my standard rate rounded to the next half hour.

After 10 minutes Reading and Responding to emails, you will be charged at my standard rate rounded to the next half hour.

I try to return all calls within 24 hours and leave an outgoing message when I am out of town and cannot call you back until I return.

I sincerely want to be available to you to a higher degree than most Therapists. During crises and court logistical times I attempt to answer the phone and texts within an hour. This is a service that I provide that can be extremely valuable, but only within reason. Discussions are best face to face.

Sessions greater than 50 minutes:

Sessions that go beyond 50 minutes will be prorated at my standard rate to the next half hour.

Emergency Procedures:

An emergency is an unexpected event that requires immediate attention and can be a threat to your help. If this happens, leave me a message on my voicemail, 805-794-7800, and call 911. If an emergency situation arises, please state this when you leave your message and I will return your call as soon as possible.

Consent for Treatment:

I hereby authorized the request Thomas D Carver, MA LMFT, to carry out psychological examinations, diagnostic procedures, and/or treatment, which now or during the course of my care as a patient are advisable

I understand that the purpose of any procedure will be explained to me and be subject to my agreement.

I have read and fully understand this Therapeutic Contract/Informed Consent of Treatment.

Client signature: _____ Date: _____

Client signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

Acknowledgement California Notice of Privacy Practices

The law requires that all patients be given a copy of the California Notice Form. The Notice describes in detail how patient health information is used and shared with others. All reasonable efforts will be made to protect the privacy of patient health information, whether it is maintained on paper or electronically, regardless of how it is communicated

I hereby acknowledge that I received the California Notice Form (Notice of Privacy Practices)

Name (print): _____

Signature: _____

Date: _____ Date of Birth: _____

Name (print): _____

Signature: _____

Date: _____ Date of Birth: _____

When a patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

Name (print): _____

Signature: _____

Date: _____ Relationship to Patient: _____

NOTICE OF PRIVACY PRACTICES

1. This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
2. **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 healthcare 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 disclose 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 change 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. You can also request a copy of this notice from me, or you can review a copy of it in my office or at my website, which is located at www.thomascarver.com.

3. **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 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.

   **** It is the general policy of each Sespe Counseling Center therapist to obtain written consent before disclosing any patient information.

   a. Uses and disclosures relating to treatment, payment or Healthcare operations do not require your prior written consent. I can use and disclosure of Phi without your consent for the following reasons:
      i. **For treatment** 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 you're being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care.
      ii. **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 company, claims processing companies, and others that process my healthcare claims.
      iii. **For healthcare operations.** I can 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 healthcare professionals who provide such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I'm complying with applicable laws.
      iv. **Other disclosures.** I may also disclose your Phi to others without your consent in certain situations. For example, your consent is not required if you need emergency treatment, as long as I try to get you or consent after treatment is rendered, or if I tried 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 Uses and Disclosures Do Not Require Your Consent. I can use and disclose your PHI without your consent or authorization for the following reasons:

i. **When disclosure is required by federal state, or local law, judicial or administrative proceedings, or law enforcement.** For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect or when ordered in a judicial or administrative proceeding.

ii. **For public health activities.** For example, I may have to report information about you to the County coroner.

iii. **For health oversight activities.** For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a healthcare provider organization

iv. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research

v. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, I may provide PHI two law enforcement Personnel or persons able to prevent or lessen such harm.

vi. **For specific government functions.** I may just close PHI of military personnel and veterans in certain situations. And I may just close PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

vii. **For workers compensation purposes.** I may provide PHI in order to comply with workers compensation laws.

viii. **Appointment reminders and health related benefits or Services.** I may use PHI to provide appointment reminders or give you information about treatment Alternatives or other health care services or benefits I offer.

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

i. **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 ask for 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.

4. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect ot your PHI.

a. The Right to Request Limits on Use and Disclosures of your PHI. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

b. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, email instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

c. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request 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 you 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 Get a List of the Disclosures I Have Made.** You have the right to get a list of instances in which I have disclosed your PHI. the list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or Health Care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to Corrections, or law enforcement Personnel, or disclosures made before April 15th, 2003.

   I will respond to your request for an accounting of disclosures within 60 days of receiving your 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 of the disclosures, to whom 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 will charge you a reasonable cost based fee for each additional request.

e. **The Right to Correct of Update Your PHI.** Do 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 a request to correct or update your PHI. I may deny a 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 stay 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 you PHI.

f. **The Right to Get This Notice by E-mail.** You have the right to get a copy of this notice by email. Even if you have agreed to receive notice via email, you also have the right to request a paper copy of it.

5. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES.

If you think that I may have violated your privacy rights, or you disagree with the 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

6. 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: Thomas Carver, 155 Granada Street, Suite O, Camarillo, CA , 805-794-7800, thomas@thomascarver.com

7. EFFECTIVE DATE OF THIS NOTICE.

This notice went into effect on April, 1, 2024.