

**ANGELA M. PFEIFFER, Ph.D.**  
**Clinical Psychologist**  
12946 Dairy Ashford, Suite 260  
Sugar Land, TX 77478  
Ph: 281-242-2595 / Fax: 281-242-2909

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**Consent for Evaluation/Treatment**

Client's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I \_\_\_\_\_, hereby give full consent to receive services of Angela M. Pfeiffer, Ph.D. until I notify her or she determines services are no longer appropriate or will no longer be provided.

**CONFIDENTIALITY**

I understand that any information I provide to Angela M. Pfeiffer, Ph.D. is confidential and generally will not be released to others without my written consent. However, I understand that professional ethical obligations, state and/or federal law might require Angela M. Pfeiffer, Ph.D. to disclose confidential information without my consent in certain circumstances. I understand Angela M. Pfeiffer, Ph.D. may be required to disclose confidential information, without my consent, in one or more of the following situations:

In the event that the therapy session reveals any information concerning the abuse of a child, elder or disabled person, Angela M. Pfeiffer, Ph.D. is mandated by law to make a report to the proper authorities. By signing this document, I acknowledge my awareness of this fact.

If the course of therapy reveals any intent I may have to harm either myself or others, I acknowledge Angela M. Pfeiffer, Ph.D.'s legal and moral duty to prevent me from bringing this harm about. I specifically give my irrevocable permission to warn those parties she feels may be harmed. If I reveal an intent to harm myself, Angela M. Pfeiffer, Ph.D. has my permission, also irrevocable, to prevent me from accomplishing that intent.

If I have been referred to this practice by a managed care or insurance company, or I plan to request Angela M. Pfeiffer, Ph.D. file for reimbursement with a managed care or insurance company, I am aware of this arrangement. As a requirement of the managed care or insurance company, I understand Angela M. Pfeiffer, Ph.D. may be required to provide them with a complete copy of the records generated in my therapy. Once these records are in the possession of the managed care or insurance company, Angela M. Pfeiffer, Ph.D. cannot guaranty their continued confidentiality.

Additionally, if a lawsuit is filed by me against Angela M. Pfeiffer, Ph.D. for breach of duty; or if a court order, legal proceeding, statute, or regulation requires disclosure of records, I understand legal obligations may require the release of my therapy records.

**RECORDS**

I understand it is stated law that psychologists maintain a record of the treatment given to me. This record will contain the information that will allow Angela M. Pfeiffer, Ph.D. to chart the course of therapy. She will use it only for that purpose. It is her intent that no one will ever see what is contained in the file. I understand I may get a copy of the file only by providing her with a signed release of information request. Angela M. Pfeiffer, Ph.D. may provide me with a synopsis of the course of treatment and outcome in lieu of the actual record. I agree I will pay in advance for either the copying cost of the actual record or the time required for the preparation of the treatment summary. This includes providing copies or reports to any court or legal representative or designate.

If the therapy sessions contain more than one patient, I agree that no one person may get the complete treatment file. I agree Angela M. Pfeiffer, Ph.D. may synopsise the course of each individual's treatment as opposed to providing a copy of what notes may have been made during any therapy session.

If I have been referred to this practice by a managed care or insurance company, or I plan to request Angela M. Pfeiffer, Ph.D. file for reimbursement with a managed care or insurance company, I am aware that she may have to waive my right to confidentiality as it pertains to in the managed care or insurance company. If she is an approved provider, she may have to share all the

information I provide with this organization. I understand Angela M. Pfeiffer, Ph.D. will do so as required to get me all the treatment that is appropriate. I am aware that the organization is not bound by her ethical and legal requirements on maintaining the confidentiality my treatment may require. Once these records are in the possession of the managed care or insurance company, Angela M. Pfeiffer, Ph.D. cannot guaranty their continued confidentiality.

In the event that Angela M. Pfeiffer, Ph.D. becomes incapacitated or dies, it will become necessary for another therapist to take possession of your files and records. By signing this form, you give your consent to allow another licensed mental health professional, selected by Dr. Pfeiffer, to take possession of your records and provide you with copies upon request, or to deliver them to a therapist of your choice.

**PAYMENT**

I understand payment is due at the time of service. Payment schedule will be made known to me before my initial session.

**MISSED PAYMENTS**

I understand if I do not uphold my responsibility to pay for services, this may result in the termination of treatment with Dr. Pfeiffer and referral for appropriate treatment services elsewhere.

**MISSED SESSIONS**

If I need to cancel a session with Angela M. Pfeiffer, Ph.D., I agree to provide at least 24 hours notice. If I do not provide this notice, I understand I will be billed \$75.00. After 2 sessions in which I failed to give at least 24 hours notice, I will be billed the full amount of the session.

**THERAPIST'S INCAPTACITY OR DEATH**

In the event that your therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of your files and records. By signing this form, you give your consent to allow another licensed mental health professional selected by your therapist to take possession of your records and provide you with copies upon request, or to deliver them to a therapist of your choice.

**TERMINATION OF TREATMENT**

I understand the length of time required for therapy will be determined by my personal situation. I understand Angela M. Pfeiffer, Ph.D. will do her best to fulfill my therapeutic needs and to provide me with her best professional care. For my part, I agree to participate in the process as needed to the best of my ability. It is intended that when my needs are met, to the extent that they can be, we will terminate our relationship. There is no guarantee of a cure.

I understand I may terminate treatment at any time. This may be accomplished in any one of several ways. These include, but are not limited to, putting it in writing, informing her verbally, failing to maintain my appointment schedule without proper notification, or failure to follow treatment recommendations. I understand Angela M. Pfeiffer, Ph.D. will respect my wishes to terminate treatment. I also understand the method I choose to accomplish termination will impact any decision to resume a therapeutic relationship with her.

My signature on this consent form verifies that I have had the opportunity to ask questions regarding procedures, policies, and therapeutic techniques, that my questions were answered to my satisfaction by Angela M. Pfeiffer, Ph.D., and that I voluntarily give my consent for treatment. I understand that I have the right to withdraw my consent for treatment at any time.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
Date

**INFORMED CONSENT FOR TELEHEALTH SERVICES**

Should we decide that telehealth services are appropriate and useful for you treatment, please read and sign the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- Please provide a phone number where you or your parent/guardian can be reached in the event of technical problems: \_\_\_\_\_
- Please provide at least one emergency contact and the closest ER to your location, in the event of a crisis situation.

Emergency Contact: \_\_\_\_\_

- If you are not an adult, we need the permission of your parent/legal guardian for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Psychologist Signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Signature of Guardian: \_\_\_\_\_

Date signed: \_\_\_\_\_

## ADULT HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Spouse/Significant Other: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_

Can I leave a message on this line? Yes No

Work Phone: \_\_\_\_\_

Can I leave a message on this line? Yes No

Cell Phone: \_\_\_\_\_

Can I leave a message on this line? Yes No

Alternate Phone: \_\_\_\_\_

Can I leave a message on this line? Yes No

If I may need to reach other family members (such as spouse or children), please provide their phone numbers below:

Name of family member: \_\_\_\_\_

Phone: \_\_\_\_\_

Can I leave a message on this line? Yes No

*Occasionally it is easier to communicate about appointments through email than phone. If you would like the option of communicating about issues such as appointments, scheduling, payments, etc, please list email addresses below. It is important to note however, that email is not a 100% secure form of communication and thus privacy cannot be guaranteed. Email will not be used for advice, treatment, or any other form of intervention with your provider. By listing email addresses below, you are acknowledging your understanding of these statements.*

Email address: \_\_\_\_\_

How did you find out about me? \_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_

Phone and Fax Number: \_\_\_\_\_

Please state why you are seeking therapy at this time: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

At what age was the problem first noticed? \_\_\_\_\_  
\_\_\_\_\_

What are you hoping to achieve with therapy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ACADEMIC INFORMATION

Highest level of education achieved: \_\_\_\_\_

Did you receive any formal or informal modifications at school? Please describe: \_\_\_\_\_

\_\_\_\_\_

Current Employment Status: \_\_\_\_\_

Are you satisfied with your employment? \_\_\_\_\_

FAMILY

Please list family members who live in the home and their ages:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any family members who live elsewhere? If so please list their names, ages and reason for moving out:

\_\_\_\_\_

Marital Status, if applicable, please include any relevant dates of marriage, divorces, separation, etc: \_\_\_\_\_

\_\_\_\_\_

If divorced with children, please describe custody arrangements: \_\_\_\_\_

\_\_\_\_\_

RECREATION / SOCIAL

How do you spend free time? \_\_\_\_\_

\_\_\_\_\_

What are your favorite hobbies and interests? \_\_\_\_\_

\_\_\_\_\_

Are you satisfied with your social network: \_\_\_\_\_

\_\_\_\_\_

Please check the following activities in which you participated in the last month:

- Exercised or played a sport, how frequently? \_\_\_\_\_
- Spent time with friends, how frequently? \_\_\_\_\_
- Engaged in volunteer activities, what activities? \_\_\_\_\_
- Watched TV/played on Internet, how many hours/day? \_\_\_\_\_

Played videogames or computer games, how many hours/day? \_\_\_\_\_

Please describe your strengths: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**STRESSORS**

Has your family experienced any stressful events in the last year? Please check the following

- Death in the family
- Death of a close friend
- Serious illness or injury, you
- Serious illness or injury, a loved one
- Family fighting
- Marital problems
- Divorce or separation
- Marital reconciliation
- Problems with child rearing
- Move to a new home
- Son or daughter leaves home
- Conflict with in-laws
- Change in job - new position, new company, laid off, retired, quit
- Change in financial status, either more or less money
- Change in daily responsibilities
- Change in social network
- New marriage in the family
- Outstanding personal achievements

Any other stressors experienced by you or your family? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL**

Do you have any of the following medical problems?

<u>Current</u>	<u>Past</u>		<u>Current</u>	<u>Past</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury
<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries
<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	Tics
<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, Type I	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained pains
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, Type II	<input type="checkbox"/>	<input type="checkbox"/>	PMS symptoms
<input type="checkbox"/>	<input type="checkbox"/>	Overweight	<input type="checkbox"/>	<input type="checkbox"/>	Muscle tension
<input type="checkbox"/>	<input type="checkbox"/>	Underweight	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Back or neck pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use/abuse	<input type="checkbox"/>	<input type="checkbox"/>	Drug use/abuse

If you checked any of the boxes above, please describe the problem: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any other medical problems not listed above that you experience? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
Are you currently taking any medications? If so, please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe your sleep habits? How many hours per night of sleep are typical? Do you have any concerns about your sleep? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How much alcohol do you drink per week? \_\_\_\_\_

Do you use any illicit drugs? If so, which ones and how often? \_\_\_\_\_  
\_\_\_\_\_

Do you smoke nicotine? If so, how much? \_\_\_\_\_

Are there any medical problems someone in the family has that may be impacting you? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MENTAL HEALTH

How would you describe your overall mood? \_\_\_\_\_

Have you sought psychotherapy before? If so, what were the circumstances? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you find therapy helpful? \_\_\_\_\_

If you are taking medication for emotional or behavioral struggles, what medication(s) and who is the prescribing physician? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the medication helpful? \_\_\_\_\_

Have you taken medication in the past for emotional or behavioral struggles? If so, what medication(s) and effective was each one? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any history of abuse? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check all that apply:

	Self, current	Self, past	Mother	Father	Sibling	Other
Depression, sadness						
Anxiety / Excessive Worries						
Obsessions and/or Compulsions						
Autism/PDD/Asperger's						
Tourette's Syndrome						
Panic Attacks						
Obsessions and/or Compulsions						
Suicidal thoughts / Suicide attempt						
PTSD						
Learning Disabilities						
Attention Deficit/Hyperactivity						
Problems with Anger						
Problems with Assertiveness						
Oppositionality/Defiance						
Schizophrenia or Psychosis						
Bipolar or manic episodes						
Heavy Alcohol Use						
Drug Use/Abuse						
Eating Disorder						
Abused in any way						
Other:						

Do you have any other comments that you think would be helpful? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

THANK YOU!



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**PAYMENT AGREEMENT**

**Self Pay/ Out of Network:**

Initial Evaluation	\$200	per 60 minutes session
Psychotherapy	\$200	per 50-60 minutes session
Group Psychotherapy	\$200	per 50-60 minutes session
Class	\$200	per 60-minute class
Legal Fees	\$300	per hour, \$80 per 15 minutes
Including phone time, report/letter writing, travel		
A retainer may be required. Determined on a case-by-case basis		
Copying Records	\$1.00	per page
Letters	\$75	per 30 minutes

**In-Network Benefits:**

Your insurance has quoted us the following information on this date: \_\_\_\_\_. However, information reported to us is not a guarantee of benefits, and benefits are subject to change at any time. We will work under the assumption that the following terms are applicable per verification of your benefits. Should we be informed of insurance nonpayment of services or changes in the information below, you will be notified as soon as possible:

Deductible: \_\_\_\_\_

Co-Payment/session: \_\_\_\_\_

Authorization #: \_\_\_\_\_

**Submission of Claims:**

Please be advised that our office will make 2 good faith efforts to collect from your insurance company. If unsuccessful, patient will be required to provide payment in full and documentation of unsuccessful efforts will be provided.

**Missed Appointments**

24 hours notice of cancellation is requested

Less than 24 hours or no notice of cancellation: \$75 fee per late or no notice cancellation

After 3<sup>rd</sup> missed appointment: \$200 fee per late or no notice cancellation

I understand and agree to all of the above information.

**Name of Patient:** \_\_\_\_\_  
*(please print) Last First Middle*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ANGELA M. PFEIFFER, PH.D., P.C.**  
**Clinical Psychologist**

**NOTICE OF PRIVACY PRACTICES**

IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH), TEXAS MEDICAL PRIVACY ACT (TX HB300), THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AS WELL AS HOW YOU MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY AND SIGN THE ACKNOWLEDGEMENT OF RECEIPT.

Protecting Your Personal and Health Information

This notice will explain how we handle your medical/mental health information. Applicable federal and state laws require us to maintain the privacy of clients' personal and health information. In this Notice, your personal or protected health information is referred to as "health information" or "PHI" and includes information regarding your health care and treatment with identifiable factors, such as your name, age, address, income or other financial information. Because state and federal laws, combined with our professional ethics, are very complicated, some parts of this notice are very detailed and may seem difficult to understand. Please know ANGELA M. PFEIFFER, PH.D., P.C. is committed to protecting the privacy of your health and personal information and is available to answer any questions you may have.

How We Protect Your Health Information

ANGELA M. PFEIFFER, PH.D., P.C. protects your health information by treating all of your health information that she collects as confidential (for exceptions to confidentiality see Uses and Disclosures Not Requiring Consent or Authorization), by training all staff in federal and state confidentiality policies and practices per HIPAA, HITECH, AND TX HB300, by restricting access to your health information only to those office staff that need to know your health information in order to provide service to you, and by maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your health information. Your health information is maintained on file after termination of services for a minimum of 7 years, or three years after the age of majority, whichever is greater.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

ANGELA M. PFEIFFER, PH.D., P.C. may use or disclose your protected health information for treatment, payment, and health care operations purposes if you have given consent to receive evaluation or treatment services.

Clarification of terms:

PHI- information in your health record that could identify you.

ePHI- information in your health record available in electronic format.

Treatment, Payment, and Health Care Operations

Treatment- when office provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when our office consults with another health care provider, such as your family physician.

Payment- when you provide reimbursement for the services you receive in the office. An example of payment would be when our office discloses your PHI/ePHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations – are activities that relate to the performance and operation of our office. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, case management and care coordination, and conducting training and educational programs or accreditation activities.

Use – Activities within the office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

Disclosure – Activities outside of the office, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

ANGELA M. PFEIFFER, PH.D., P.C. and any administrators of her may use or disclose PHI/ePHI for purposes outside Treatment, Payment, or Health Care Operations when your authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when the office is asked for information for purposes outside of Treatment, Payment, or Health Care Operations, we will obtain an authorization from you before releasing this information.

Specific authorization is also obtained before releasing your psychotherapy notes. Psychotherapy notes are notes made about treatment and are given a greater degree of protection than PHI/ePHI.

You may revoke all such authorizations at any time, provided each revocation is in writing. After that time, we will not use or disclose your information for the purposes originally agreed upon. However, we cannot take back any information already disclosed with your permission or that we had used in our office.

Uses and Disclosures Not Requiring Consent or Authorization

The law requires ANGELA M. PFEIFFER, PH.D., P.C. use or disclose PHI/ePHI without your consent or authorization in some

cases. Here are some examples of when this might occur:

When Required by Law - Suspected child abuse must be reported. Also, if you are involved in a lawsuit or legal proceeding and the provider receives a subpoena, discovery request, or other lawful process, some of your PHI/ePHI may have to be released. This will occur only after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information being requested. Finally, some information has to be disclosed to governmental agencies, which check on providers to see that privacy laws are being obeyed.

For Law Enforcement Purposes – Information may be released if your provider is asked to do so by a law enforcement official to investigate a crime or criminal.

For Public Health Activities – Some of your PHI/ePHI might be disclosed to agencies which investigate diseases or injuries.

For Specific Government Functions – PHI/ePHI of military personnel and veterans may be disclosed to government benefit programs relating to eligibility and enrollment. PHI/ePHI may also be disclosed to Workers Compensation and Disability Programs, to correctional facilities if you are an inmate, and for national security reasons.

To Prevent a Serious Threat to Health or Safety – If your provider believes that there is a serious threat to your health or safety or that of another person or the public, the provider can disclose some of your PHI/ePHI. This disclosure will only be provided to persons who can prevent the danger.

Therapist's Incapacity or Death – In the event that your provider becomes incapacitated or dies, it will become necessary for another therapist to take possession of your files and records.

### Patient Rights and Provider's Duties

#### Patient Rights:

Rights to Request Restrictions – You have the right to request that your provider limits what is told to people involved in your care or the payment of your care, such as family members and friends. ANGELA M. PFEIFFER, PH.D., P.C. may not be able to accept your request; however, if accepted she will uphold it except in case of emergency or if it is against the law.

Right to Receive Confidential Communications by Alternative Means/Locations – You have the right to request and receive confidential communications of PHI/ePHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at the office. On your request, communications will be sent to an alternate address.)

Right to Inspect and Copy – You have the right to inspect and/or obtain a copy of your records. A reasonable fee may be charged for copying. Access to your records may be limited or denied under certain circumstances, but in most cases you have a right to request a review of that decision. On your request, we will discuss with you the details of the request and denial process.

Right to Amend – You have the right to request in writing an amendment of your health information for as long as PHI/ePHI records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, we will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI/ePHI. If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.

Electronic vs. Paper – If you received this notice electronically (e.g., accessing a website) you have the right to obtain a paper copy of the notice from the office upon request.

#### Duties of ANGELA M. PFEIFFER, PH.D., P.C. :

Provider is required by law to maintain the privacy of PHI/ePHI and to provide you with this notice of legal duties and privacy practices.

ANGELA M. PFEIFFER, PH.D., P.C. reserves the right to change the privacy policies and practices and terms of this Notice at any time, as permitted by applicable law. She reserves the right to make the changes in privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Unless we notify you of such changes, however, the office is required to abide by the terms currently in effect.

Provider is also required to notify you if there is a breach of your PHI/ePHI which would allow your clinical or financial information to be identified or compromised.

### Questions and Complaints

For questions regarding this Notice of our Privacy Practices, or if you are concerned that your privacy rights may have been violated, please contact ANGELA M. PFEIFFER, PH.D., P.C. . You may also make a written complaint to the US Department of Health and Human Services, whose address can be provided upon request. If you choose to make a complaint with the US Department of Health and Human Services, or with me, I will not retaliate in any way.

ANGELA M. PFEIFFER, PH.D., P.C.

12946 Dairy Ashford, Suite 260

Sugar Land, Texas 77478

281-242-2595

**ANGELA M. PFEIFFER, PH.D., P.C.**  
**Clinical Psychologist**

**CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT,  
PAYMENT, OR HEALTH CARE OPERATIONS**

In my notice of Privacy Practices, I provide you with information about how I can use or disclose your personal and health information. As described in my Notice of Privacy Practices, I request your consent for use or disclosure of mental health and medical information to carry out treatment, payment, or health care operations. You have a right to review my Notice of Privacy Practices before signing this Consent form.

By signing this Consent form, you: (1) Acknowledge that a copy of the Notice of Privacy Practices has been provided to you; and (2) Consent to our use and disclosure of your health information for treatment, payment, or health care operations, as described in the Notice of Privacy Practices.

You have the right to revoke this Consent in writing any time, except where we have already used or disclosed your health information in reliance upon this Consent.

I am required by law to notify you if there is a breach of your PHI/ePHI which would allow your clinical or financial information to be identified or compromised.

\_\_\_\_\_  
Patient's Name (Printed)

\_\_\_\_\_  
Signature of Patient, Parent, or Legal Representative

\_\_\_\_\_  
Date