Adejoke Jegede, Ph.D.
Clinical Neuropsychologist

Main Office: 2311 Mustang Drive, Suite 200 Grapevine, TX 76051
Satellite Office: Arlington Highlands, Arlington, TX 76018
Ph. (817) 600-8892 / Fax: (682) 503-6106

HISTORY FORM

Instructions to Patient: Please fill out to best of your knowledge. Write **N.A.** if not applicable. Circle appropriate answers where indicated. Continue on attached blank paper if necessary and add any additional comments you wish to make.

Patient's Name: _____ Age: ____ Date of Birth: _____

Home Address: _____ Phone: _____

_____

Who referred you for neuropsychological Evaluation?

Name: _____ Profession (Specialty):_____

Address: _____ Telephone: _____

_____

Reason for Referral: _____

_____

_____

_____

Medical Insurance:

Primary Insurance Name:_____ Number: _____

Secondary Insurance Name:_____ Number: _____

Current Symptoms (Emotional, Behavior, Physical, etc):

1. _____

2. _____

3. _____

4. _____

Are you currently experiencing difficulties with:

Concentration	Yes / no	Speech/Language	Yes / no
Organization	Yes / no	Walking	Yes / no
Getting lost	Yes / no	Depression	Yes / no
Memory	Yes / no	Anxiety	Yes / no

Current Treatments:

Doctor	Specialty	Reason for treatment
1.		
2.		
3.		
4.		

BACKGROUND INFORMATION

Place of Birth: _____ First Language Spoken: _____

Current Primary Language: _____ At what age did you learn English? ____

Other languages spoken: _____

If born outside of the U.S., what year did you immigrate? _____

Handedness

Which hand do you use to write? _____
Which hand do you use to throw a ball? _____
Did you ever change handedness? _____

EDUCATION HISTORY

Elementary School

Name of institution: _____ Location: _____

Did you graduate: Yes _____ No _____

Did you have trouble learning to read? Yes _____ No _____

Did you have trouble spelling? Yes _____ No _____

Did you have trouble with math? Yes _____ No _____

Did you have other learning difficulties? Yes _____ No _____
Specify: _____

Were you ever left back Yes _____ No _____

When/where: _____

Were you classified as learning disabled? Yes _____ No _____

Attention Deficit Disorder? Yes _____ No _____

Did you attend Special Education? Yes _____ No _____

High School

Name of institution: _____ Location: _____

Did you graduate: Yes _____ No _____ Year of Graduation_____
If No, during which grade did you leave school? _____
Why did you leave? _____Did you obtain your GED? _____

Were you ever left back? Yes ____ No____

College/University

Name of institution: _____

Major: _____ Degree: _____

Did you graduate: Yes _____ No _____ Year of Graduation _____

If No, how many credits did you complete? _____

Other Educational/Experience

Institution: _____Degree: _____
Did you complete the program? Yes ____ No____ Year completed _____

Institution: _____Degree: _____
Did you complete the program? Yes ____ No____ Year completed _____

SOCIAL HISTORY

Marital Status? _____ Length of Current Marriage? _____

Number of previous marriages? _____ How Many Children? _____

Residence
With whom do you currently live? _____
Type of residence (e.g. house, Apartment, etc)? _____

EMPLOYMENT HISTORY

Are you currently employed? Yes/No If No, date of last employment _____

Most recent position: Title: _____ Years Held: _____

Other Employment History:
_____

_____

MEDICAL HISTORY

Primary Care Physician _____Telephone_____

Address _____

List your **current** medications (Please use back if needed):

	Medication	Dose	Reason prescribed
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Surgeries (List most recent first):

	Procedure	Date	Reason
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Major Medical Illnesses:

	Illness	Date of diagnosis	Treatment
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Have you been involved in any of the following:

Motor vehicle accident Yes _____ No _____
When? _____ Where _____
Hospitalized for how long? _____

Substantial fall Yes _____ No _____
When? _____ Where _____
Hospitalized for how long? _____

Assault Yes _____ No _____
When? _____ Where _____
Hospitalized for how long? _____

Have you been diagnosed with any of the following? If yes, place the date of diagnosis:

	Date of Dx		Date of Dx
High Blood Pressure		Parkinson's Disease	
Heart Attack		Other movement disorder	
Stroke		Head Injury	
Transient Ischemic Attack		Loss of consciousness	Yes/No
Arteriosclerosis		Length of unconscious?	
Bypass Surgery		Allergies	
Pulmonary Disease (lung)		Sleep Apnea	
Diabetes		Pain Disorder	
Hyperthyroidism		Tic Disorder	
Hypothyroidism		Depression	
Renal disease (kidney)		Anxiety	
Hepatic disease (liver)		Bipolar Disorder	
Pituitary disease		Schizophrenia or	
Adrenal disease		Schizoaffective disorder	
Cancer:		Other psychiatric disorder	
Diagnosis:		Specify:	
Treatments:		Learning Disability	
Seizures		Attention Deficit Disorder	
Meningitis			
Encephalitis			

Have you experienced any of the following? If yes, place the date of onset:

	Date of onset		Date of onset
Periods of confusion or amnesia		Balance problems	
Headaches		Dizziness	
Poor sleep		Trouble walking	
Changes in appetite		Frequent falls	
Gastrointestinal problems		Slowed movements	
Sensory loss or tingling		Change in posture	
Change in ability to taste		Sexual dysfunction	
Change in ability to smell		Hallucinations	
Hearing problems		Delusions	
		Vision problems	

Do you currently smoke? No ___ Yes ____ Did you smoke in the past? No ___ Yes _____
Do you currently drink? No ___ Yes ____ If yes, how much:_____
Did you drink in the past?___ If yes, how much:_____
Do you currently abuse drugs? _____ If yes, describe:_____

PSYCHOLOGICAL HISTORY

Have you ever been treated with **medication**, **psychotherapy**, or other treatment (e.g. ECT, Herbal, Biofeedback etc.) for psychological, emotional, or behavioral difficulties?

	Treatment	Reason	Age	Length of treatment
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Do you view you as:

Depressed	Yes _____	No _____	Anxious	Yes _____	No _____
Angry	Yes _____	No _____	Impulsive	Yes _____	No _____

How much alcohol do you drink per week? _____
Have you ever been a heavy drinker? _____
Have you ever sought treatment for alcohol use? _____

Non-prescription/illicit drug use (weekly) _____
Have you ever used illicit drugs regularly? _____
Have you sought treatment for a chemical dependence? _____

How much do you smoke per day? _____

Current psychological stress:

Vocational difficulties	Yes _____	No _____
Educational difficulties	Yes _____	No _____
Family difficulties	Yes _____	No _____
Marital difficulties	Yes _____	No _____
Financial difficulties	Yes _____	No _____
Legal problems		
Civil	Yes _____	No _____
Criminal	Yes _____	No _____
Death of a loved one	Yes _____	No _____
Change of residence	Yes _____	No _____
Change/loss of job	Yes _____	No _____
Medical difficulties (self)	Yes _____	No _____
Medical difficulties (loved one)	Yes _____	No _____

Adejoke Jegede, Ph.D.
Clinical Neuropsychologist

Main Office: 2311 Mustang Drive, Suite 200 Grapevine, TX 76051
Satellite Office: Arlington Highlands, Arlington, TX 76018
Ph. (817) 600-8892 / Fax: (682) 503-6106

Consent Form

This document contains important information about my professional services and business policies.

NEUROPSYCHOLOGICAL ASSESSMENT
Neuropsychological assessment involves an evaluation of cognitive abilities, which may consist of computer administered tests, paper-and-pencil tests, a clinical interview and/or other assessment tools. The goal of neuropsychological assessment is to provide an understanding of the patient's cognitive function in order to assist in diagnosis, treatment planning, and/or consultation.

PROFESSIONAL INFORMATION
Dr. Jegede received her Bachelor's Degree in General Sciences with a Minor in Psychology at Duquesne University, Pittsburgh, PA. She completed her Master's Degree in Psychology at Adelphi University. She received her PhD in Clinical Psychology from California School of Professional Psychology She completed an internship at Mount Sinai School of Medicine, New York, NY. She started her fellowship at Mount Sinai School of Medicine, New York, NY and James J. Peters Veterans Affairs Medical Center (JJPVAMC), Bronx, NY. She completed her fellowship training at Long Island Jewish Medical Center, New Hyde Park, NY and JJPVAMC.

CONTACTING US
Due to my work schedule, I am often not immediately available by telephone, as I am often with a patient. My office hours are between 8:30 AM and 5 PM. When I am unavailable, please leave a message. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of the times that you will be available. However, if you are unable to reach me and feel that you cannot wait for me to return your call, please call 911, contact your family physician or go to the nearest emergency room. In addition, the Suicide and Crisis Center Hotline at 214-828-1000 is another resource for patients.

PROFESSIONAL FEES
Depending on the reason you were referred, the cost of the assessment varies. Some insurance companies cover the cost of testing in full and other insurance companies may require a copayment. Some insurance cover a certain percentage and you will be required to pay the rest. Check with your insurance company for further information on coverage. The procedure code is 96118. If you do not have insurance, you will be required to pay the fees. Cost of a brief battery can range from $150-$250/hr. A full battery will cost more. You will be provided a specific dollar amount for your particular situation before any testing takes place.

If you become involved in any legal proceedings that require my participation, you may be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. I will accept prearranged conformation of payment by the law firm requesting deposition. However, if the attorneys do not pay for my time, I will expect you to compensate me. Because of the difficulty of legal involvement, I charge $400.00 per hour for preparation and attendance at

any legal proceeding. Fees for time out of office for time and travel are based on a rate of $400.00 per hour with a minimum fee of $1600.00. If I am required to be available into the afternoon for either court testimony or deposition a full day fee of $2100.00 is required. A deposit of $1,500.00 is required a week prior to the scheduled testimony. If only a half day is required the balance of $500.00 will be refunded to you or charged back to your credit card.

If your account has not been paid for within 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, any costs incurred will be included in the claim.

Appointments not canceled 24 hours prior to the scheduled session will be charged to the individual. Fees for professional services are customarily paid at time services are provided. In order that your session and office procedures may flow most smoothly please have your check made out prior to your session. All checks should be made payable to "Adejoke Jegede" Cash may also be accepted as means of payment. Returned checks are subject to a $30.00 service charge. If your account in this office is delinquent for a period of greater than sixty days your therapist may refer you to a community agency or program to continue needed services. A delinquent account may also be turned over to an agency for collection. The agency will be given only your name, identifying information, and amount owed, but will not be provided other information about your case. In such a case, the collection agency may contact you in seeking payment for services delivered to you by your therapist.

You have the right to ask your therapist about any questions you have regarding these policies. Your signature below means that you have read and acknowledge the above office policies and agree to comply with those policies as described. Your signature also means that you agree you have had the opportunity to have answered any questions you may have about these policies and that you are giving your informed consent to participate in counseling or therapy with a treatment provider from this practice group

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. If you provide me with a written authorization to release the record to any specific person, you must revoke the release in writing if you change your mind. For example, if you provide us with a release to provide your confidential information to a physician or another healthcare provider, and then later decide to change providers, you will need to revoke the original authorization in writing. There are certain situations that do not require your consent. Following are some of those examples. It is my practice to provide you with prior notice of the primary examples. Your signature on this agreement confirms your understanding that I do not need your consent in these types of situations.

I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of our patient. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together. We will note all consultations in your clinical record (which is called "PHI" in our Notice of Policies and Practices to Protect the Privacy of Your Health Information).

If a patient seriously threatens to harm himself/herself or others, I may be obligated to seek hospitalization

for him/her, or to contact family members or others who can help provide protection, specifically including law enforcement officials. Texas law states that a professional may disclose confidential information to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others, or there is a probability of immediate mental or emotional injury to the patient. There are some situations where I are permitted or required to disclose information without either your consent or authorization:

If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-patient privilege law. However, we may be required to provide information with your (or your legal representative's) written authorization, a valid subpoena, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

If a government agency is requesting the information for health oversight activities, we may be required to provide it to them. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend the practice.

If a patient files a worker's compensation claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought. There are some situations in which I am legally obligated to take action in order to protect others from harm. This may involve revealing some information about a patient's treatment. These situations are unusual in our practice.

If I have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that we make a report to the appropriate government agency, usually the Department of Protective and Regulatory Services. Once such report is filed, I may be required to provide additional information.

If I determine that there is a probability that the patient will inflict imminent physical injury on another, or that the patient will inflict imminent physical, mental or emotional harm upon himself/herself, or others, I may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the patient. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. This summary of exceptions to confidentiality is not exhaustive.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that I discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information about you in your clinical record. The clinical record includes information about your reasons for seeking neuro-psychological test and/or therapy, a description of the ways in which the problem impacts on your life, the diagnosis, the goals that I set for treatment, progress towards those goals, medical and social history, treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone. Except in unusual circumstances that involve danger to yourself and/or others or when there is a need to protect the integrity of a test we administered, you may examine and/or receive a copy of your clinical record, upon

written request. You should be aware that pursuant to Texas law, psychoeducational test data are not part of a patient's record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we charge a copying fee of $1.00 per page (and for certain other expenses). If I refuse your request for access to your records, you have a right of review, which we will discuss with you upon your request. In addition, I also keep a set of cognitive testing notes. These notes are for my own use and are designed to assist in providing you with the best treatment. While the contents of psychotherapy notes vary from patient to patient, they can include the contents of our conversations, our analysis of those conversations, and how they impact your evaluation. They also may contain particularly sensitive information that you may reveal during your sessions that is not required to be included in your clinical record. These testing notes are kept separate from your clinical record. Insurance companies cannot require your authorization as a condition of coverage, nor penalize you in any way for your refusal. You may examine and/or receive a copy of your testing notes unless we determine that release would be harmful to your physical, mental or emotional health. If you become involved in litigation, be advised that these testing notes may be subject to release to other parties pursuant to a court order.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your clinical record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this agreement and the Texas Notice form of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND THIS AGREEMENT.

_____ _____

Patient Date

_____ _____

Adejoke Jegede, PhD Date

Clinical Neuropsychologist

Adejoke Jegede, Ph.D.
Clinical Neuropsychologist

Main Office: 2311 Mustang Drive, Suite 200 Grapevine, TX 76051
Satellite Office: Arlington Highlands, Arlington, TX 76018
Ph. (817) 600-8892 / Fax: (682) 503-6106

Liability Acknowledgment Form

You, the patient or guardian is financially responsible for services rendered.

Financial responsibility can be met if insurance benefits cover the services. Covered services are specific to your insurance plan. It is your responsibility to understand the benefits and requirements of your insurance plan. It is your responsibility to inform me of changes to your insurance.

There may be reasons why your insurance company does not cover services which you request and I provide. While I do not expect this to happen, if your insurance company denies payment, you, the patient or guardian, agree to be financially liable for and pay all charges.

There are different reasons why services may not be covered. These include:

- a service that is a non-covered benefit
- a service that your insurance company has determined to be not medically necessary
- a service which requires preauthorization which was not obtained prior to the date of service
- a service which a claim was submitted but not recognized as received by your insurance company ("untimely filing")
- other reasons specific to your insurance company

By signing below, you, the patient or guardian, understand and accept the financial responsibility for services.

_____ _____

Patient Signature Date

Adejoke Jegede, Ph.D.
Clinical Neuropsychologist

Main Office: 2311 Mustang Drive, Suite 200 Grapevine, TX 76051
Satellite Office: Arlington Highlands, Arlington, TX 76018
Ph. (817) 600-8892 / Fax: (682) 503-6106

Name of Patient: _____

Patient Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of July 01, 2011.

_____ _____
Signature of Patient/Patient Representative Date

_____
Relationship to Patient

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on [insert date] and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:
  _____
- ☐ Other reason (describe below):
  _____

Signature of Person Completing Form: _____

Date Signed: _____

Adejoke Jegede, PhD

HIPAA Notice of Privacy Practices for Protected Health Information

This notice describes how psychological and/or medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

Uses and Disclosures for Treatment, Payment, and Health Care Operations Do Not Require Your Prior Written Consent: I am permitted by federal privacy laws to use and disclose your *protected health information* (PHI) for the following purposes:

- **Treatment:** I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.
- **Payment:** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
- **For health care operations:** I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
- **Other disclosures:** Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain), I may disclose your PHI.

Uses and Disclosures without Consent or Authorization: I may use or disclose PHI without your consent or authorization in the following situations:

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against me with the State Board of Examiners of Psychologists, they have the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case**.**
- **Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical

or law enforcement personnel.

- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

Your Health Information Rights: The health and billing records we maintain are the physical property of my office. The information in it, however, belongs to you. You have a right to:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request if the information:
  - Was not created by me.
  - Is not part of the health information that I keep.
  - Is not part of the information that you would be permitted to inspect and copy.
  - Is accurate and complete.

  If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.
- *Right to Revoke Authorizations* – You have the right to revoke authorizations that you made previously to use or disclose information by delivering a written revocation to Dr. Jegede, except to the extent information or action has already been taken.

My Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will post a revised copy in the office and provide you with a copy upon request.

To Request Information or File a Complaint:

- If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Adejoke Jegede, PhD, 817-600-8892**.**
- Additionally, if you are concerned that I have violated your privacy rights, or you disagree with a

decision I made about access to your records, you may contact the Texas Board of Examiners of Psychologists at 512-305-7400. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

Effective Date: This notice went into effect on July 1, 2011.

I have been given the opportunity to receive a copy of this document as well as read it.

_____ _____

Patient/Legal Guardian Date