PEARL RANCH, LLC

Margot Luckman, M.S., L.C.P.C., C.R.C, C.M./F.
2305 Duncan Drive
Missoula, Montana 59802

Telephone: 406-542-0820
Facsimile: 406-542-0843
email: pearlranch@live.com

Agreement for Services

I, (participant) ____ for and in consideration of the agreement of Pearl Ranch, LLC, to provide Animal Assisted Activities/Animal Assisted Therapy and/or Group Learning Activities for myself and/or members of my family, attest that I have received, read, and agree to the statements, terms and conditions in the following documents (please initial before each document):

______ Release of Liability Agreement – to include all members of my family

______ Photo and Publicity Release

______ Fee Agreement

______ Cancellation Policy

______ Horse Related Activities Come with This Warning

______ Introduction to the Therapeutic Program

______ Office/Ranch Policy

______ Clothing List for Equine Activities

______ Read/Access to HIPPA

______ I also understand that Pearl Ranch, LLC, must have a "Participant's Medical History & Physician's/Nurse's Statement" for each member of the family who wishes to participate in any activity involving an Equine. Unless I initial here ______ to waive this.

______ I am also notified that if I choose not to consent to Emergency Medical Treatment on the part of Pearl Ranch, LLC, staff, who are trained in First Aid and CPR, I may be refused participation in Equine activities.

______________________________	______________
Signature of Participant	Date
______________________________	______________
Signature of Parent/Guardian if Participant is a Minor	Date
______________________________	______________
Signature of Program Personnel	Date

Client Registration Agreement
Margot Luckman, LCPC

Patient Information

Name ________________________________

SS # ______-______-______ Date of Birth __________ Male ________ Female ________

Address ________________________________ City ____________ State ________ Zip ____________

Employer____________________ Work Phone ____________Home Phone__________ Cell____________

Emergency Contact Name ________________________ Relationship ________________________

SS # ______-______-______ Date of Birth __________

Address ________________________________ City ____________ State ________ Zip ____________

Work Phone ____________Home Phone__________ Cell____________

	Primary Insurance:	Secondary Insurance:
Name of **Health Insurance** Company:		
Name of Policy Holder:		
Relationship of Policy Holder:		
Policy #:		
Group #:		
Policy Holder's S.S.N.:		
Policy Holders DOB:		
Policy Holder's Telephone #:		

I understand that my insurance company will be billed for services at the standard fee. I understand I am responsible for acquiring a physician referral if required by my insurance company for pre-authorization and/or continued authorization for mental health services. I agree to the release of basic information deemed necessary to process the insurance claim. I authorize my insurance benefits to be paid directly to Margo Luckman, LCPC. I understand I am responsible to notify this office immediately with any changes to information supplied above. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I understand that co-pays might be expected at the time of service and deductibles will be billed to me. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I further agree that a copy of this document shall be valid as the original.

The undersigned certifies that I have read this agreement, been given the opportunity to ask questions, and accept its terms.

____
Patient Signature

____
Date

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Participation Release of Liability Agreement

I, ____ (participant) for and in consideration of agreement of Pearl Ranch, LLC, to provide volunteer work in animal assisted activities, animal assisted therapy, or other duties, myself, do hereby forever release, acquit, discharge and hold harmless Pearl Ranch LLC, its officers, trustees, agents, employees, representatives, successors and assigns, for all manner of claims, demands and damages of every kind and nature whatsoever, which the undersigned my now, or in the future, have against Pearl Ranch, LLC, its members, officers, trustees, agents, employees, representatives, successors or assigns on account of any personal injuries, physical or mental condition, known or unknown, to the undersigned and the treatment therefore as a result of, or in any way growing out of, the acts of Pearl Ranch LLC, its officers, trustees, agents, employees, representatives, successors or assigns, including but not limited to, their negligence or gross negligence, in rendering the services above described or in any way incidental thereto.

UNDER MONTANA LAW, AN EQUINE ACTIVITY SPONSOR IS NOT LIABLE FOR ANY INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVIITES THAT ARE OBVIOUS AND NECESSARY. PURSUANT TO SEC. 3, CH. 119, L. 1993. 27-1727 OF THE MONTANA STATE CODE,

______________________________________ ______________________
Signature of Participant or Legal Guardian Date

______________________________________ ______________________
Name of Minor of the Legal Guardian or Parent Date

______________________________________ ______________________
Signature of Program Personnel Date

Photo and Publicity Release (Optional): I hereby consent to and authorize Pearl Ranch LLC, to use my/my child's/my ward's name in all audio, visual and written promotional material and to use and/or reproduce any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

______________________________________ ______________________
Participant's Signature/or Parent/Guardian. Date

And/Or

I consent to a picture being taken of me/my child/my ward on camera/phone provided by them or myself for personal use only.

______________________________________ ______________________
Participant's Signature/or Parent/Guardian. Date

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Fee Agreement

We are committed to providing you with the best possible care. In order to achieve this goal, we need your understanding of our payment policy.

Payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance by Margot Luckman. We accept checks, money orders and credit payments through PAYPAL. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month. At minimum, there is a $25 fee for returned checks.

Please be aware that your insurance company may not cover services provided by Pearl Ranch LLC. Your insurance coverage is a contract between you, your employer and the insurance company. Pearl Ranch. LLC is not a party to that contract. Some insurance companies arbitrarily select certain services they will not cover.

As a mental health care provider and learning facilitator, our relationship is with you, not your insurance company. All charges are your responsibility on the date the services are rendered.
We will gladly bill you for services and help you to work out a payment plan. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information PLEASE do not hesitate to ask.
Appointments are scheduled for 45-50 minutes per session. Children must be in the custody of an adult until a Pearl Ranch, LLC staff member is providing direct care to that child. Children must be picked up at the end of the session on time, in consideration of other clients. A fee will be assessed in 15 minute increments for supervising the child at a rate of $5, or $20 per hour.
Insurance does not cover this fee.

Cancellation Policy:
If you need to cancel your appointment, we require 24 hour's notice. If you do not provide 24 hour's notice, your session will be considered a missed appointment. If your insurance company or other funding will not pay for a missed appointment, you will be responsible for full payment of the session.

Medicaid clients, fees as follows: First missed appointment: $5 fee, Second missed appointment, $10 fee, Third missed appointment, $25 fee and loss of your time slot each week.

______________________________ _______________
Participant Signature Date

______________________________ _______________
Guardian of above minor participant Date

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Clothing List for Equine Activities

ALL sessions involving equine-assisted mental health sessions are held outdoors, or in a barn or arena when available. As such, you are exposed to unheated buildings and unpredictable weather conditions. It is IMPERATIVE that you dress appropriately. Below is a list of weather conditions and suggested apparel. Please note – there are no extra jackets, sweaters, boots, etc. at our facility. It is better to over-dress and be able to remove clothing than it is to underdress and become chilled or uncomfortable. It is always advisable to wear sunscreen on exposed parts of the body. Please remember that you are dressing to work outside and with a horse – conditions are sometimes muddy and dirty. Very causal, warm and comfortable clothing is always appropriate. Even in the summer time, long pants (not shorts) are recommended in the barn or with the horse. Baggy pants are not permitted – you need to be able to move freely with no fear of tripping, falling, or becoming tangled in props or equipment because of excess clothing.

COLD WEATHER
Wear layers of clothing: shirts, turtlenecks, sweaters, jackets, etc. Please wear multiple pairs of socks and warm, waterproof shoes or boots. Even if the weather is moderate, the ground may be cold, muddy or damp. Please wear a hat and make sure that your hands are covered. Gloves are preferred to mittens so that you have use of your fingers.

WARM/COOL WEATHER
It is advisable to wear layers of clothing since the air inside may be cool even if it is warm outdoors. Shirts under sweatshirts under jackets are ideal, as you'll be able to remove clothing if it gets warm or if we move outdoors where you'll be in the sun. Warm, waterproof boots or shoes are desirable.

HOT WEATHER
In spite of hot days, the air inside a barn or arena may feel cool (if we have the opportunity to work indoors). Layers of clothing are recommended – a tank shirt under a long sleeved blouse or shirt, for example. That way, you can remove clothing if you get warm and retain clothing if you are in a cool area. Waterproof shoes **(NO SANDALS!)**, or OLD shoes are recommended. Leather as opposed to canvas shoes protect the foot better if the horse should step on you. Conditions may be muddy or dirty. Long pants (not shorts) are recommended.

______________________________ ______________
Participant's Signature Date

______________________________ ______________
Signature of Parent/Guardian if Participant is a Minor Date

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Office/Ranch Policy

Dear Clients and Families:

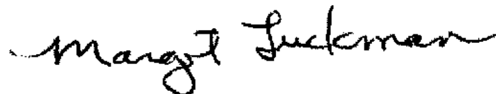
It is our pleasure to work with you, a member of your family or with your business associates. Office hours at Pearl Ranch, LLC are by appointment only. We try to be flexible to accommodate your work/school timetables. On the other hand, the equine program brings an increasing number of responsibilities that we must also attend to, and our ability to accommodate every family's work and school routine is limited at times. We do have certain times reserved for family or other outside responsibilities.

We included the equine program in 2013 to facilitate growth of the equine-assisted learning and therapy programs. We have found that our work in the pastures and the arena make casual clothing welcome and necessary. We also enjoy the relaxing environment and have a need to maintain our home environment in the midst.

Therefore, we ask that clients and families maintain scheduled times to visit us at the ranch. That way, we know that you are coming and are ready, willing and able to share time with you. Please check in with us at the office upon arrival before entering the rest of the land. If we have time to visit with the animals prior to a session or if you want to share something in particular with a family member, we will try to accommodate your request. I must ask that NO client, parent/family member or business associates enter the rest of our land, buildings, pasture or arena area without one of us. These restrictions are to ensure everyone's safety and must be strictly adhered to.

Having said that, we want you to know that Pearl Ranch is a warm, friendly environment; we hope that our policies won't damper anyone's spirits. The work done here is fun and it easily generates excitement and love. We hope that you enjoy and have fun on our ranch and equine-assisted experiential learning/counseling program.

Best Regards,



Margot Luckman, M.S., C.R.C., L.C.P.C., E.S., C.M./F.
Advanced EAGALA Certified

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Participant's Medical History & Physician's/Nurse's/or Guardian/Parent Statement

Participant Name: ______________________________ DOB: ____________________

Address: ____

Name of Parent or Guardian:

____

Tetanus Shot: **Yes / No** Date: ____________ Height: ________ Weight: ______

Current Medications: ____

____

Please indicate if client has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment, using back of form if necessary.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory (inc. Hemophilia)			
Pulmonary			
Neurological			
Muscular			
Orthopedic (incl. Spinal/Joint Abnormalities)			
Allergies (incl. Asthma)			
Learning Disability			
Mental Impairment			
Psychological Impairment (incl. Behavioral)			
Diabetes (not restrictions if any)			
Other:			

Guardian/Parent OR PHYSICIAN/NURSE MUST SIGN BELOW FOR ALL CLIENTS

In my opinion this patient can participate in supervised equestrian activities.

Signature: ______________________________ **Date:** ______________

Complete Address: ____

OR

Client/Patient/Guardian Signature ____________________________________

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Authorization for Emergency Medical Treatment

Name: ______________________________ Date of Birth: ______________________
Address: ____
Telephone Numbers: __________ home; ____________ cell; ________, __________ others
Medical Providers: Physician: ____
Others: ____
Health Insurance Company: ____
Policy Number and Information: ____
Current Medications:

Treatment	Medication	Dose	Physician

In the event of an emergency, contact the following parties:
Name: ______________________ Telephone: ____________ Relationship: __________
Name: ______________________ Telephone: ____________ Relationship: __________
Name: ______________________ Telephone: ____________ Relationship: __________

In the event emergency medical treatment or assistance is required for an reason while on the property of Pearl Ranch, I authorize Pearl Ranch to: Secure and retain medical treatment and transportation if needed, and release client records upon request to the authorized medical providers or emergency medical providers providing treatment.

Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Consent Signature: ____ Date: __________
Client, Parent or Legal Guardian
Legal Guardian or Parent of: ____

Non-Consent Plan

I do not give my consent for emergency medical treatment in the case of illness or injury while on the property of Pearl Ranch, LLC. In the event an emergency treatment is required, I wish the following procedures to take place: ____
____
____

Consent Signature: ____ Date: __________
Client, Parent or Legal Guardian
Legal Guardian or Parent of: ____

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HORSE RELATED ACTIVITIES COME WITH THIS WARNING

Protective Attire

I am hereby advised to always wear hard-soled, fully enclosed shoes or boots and socks to protect feet and long pants to protect legs while working around or interacting with horses.

The Nature and Physical Character of the Horse

Domesticated, well-trained horses are usually obedient, docile and affectionate.
However, it is important to understand that their survival instincts are what have allowed the horse to survive from prehistoric times to the present day.
I am advised that horses are unpredictable by nature, with minds of their own, as are all animals both domestic and wild. The horse is often somewhat high strung or nervous by nature.
Horses are extremely strong and physically powerful.
Horses are extremely heavy weighing from 600 to 1300 pounds on the average.
These characteristics deserve a human being's utmost respect.

I am advised that when a horse is frightened, angry, under stress or feels threatened, it is the horse's instinct to jump forward or sideways, to run away from danger at a trot or gallop of speeds up to 35 miles per hour.

I am advised that if a horse is frightened or feels threatened from behind, the horse may kick straight back, sideways in either direction or even forward with either or both hind legs with tremendous force.

I am advised that if a horse is frightened or feels threatened from above or from his/her back, he/she may hunch the back and buck in a way that could throw a rider to the ground with tremendous force. A fall from a horse will usually be from a height of 3 to 6 feet.

I am advised that if a horse is frightened or feels threatened from the front, the natural reaction may be to rear up with both front legs, strike with one or both front legs, bite with teeth, throw the head up or from side to side, or run directly over whatever he/she fears in front of him/her.

I am advised that a human must always approach a horse calmly and quietly with caution, preferably to the horse's shoulder or lower neck, talking soothingly to the horse.

I am advised that loud and/or sudden unexpected movements, dropping of objects near a horse, approaching vehicles or animals or people, ill- fitting equipment or physical pain can provoke a domesticated horse to react according to natural, protective instincts.

I am advised that the first signs of anger or fear in a horse are the sudden tensing of the muscles of the body, possibly laying the ears flat back against the head, or quickly tossing or raising the head, or sudden snorting through the nostrils accompanying at least one other warning sign.

I am advised that a horse can see independently with each eye, actually looking in one direction with one eye and another direction with the other eye. The horse can also focus both eyes on one object somewhere in front of him/her. Typically the direction the ear is pointing will tell an observer where the eye is looking on the same side.

I am advised that a horse has two blind areas around which he/she cannot see.
Those areas are directly behind the horse and directly in front. When a horse has his/her head lowered to the ground, the spot directly at the end of the nostrils is a blind area. This is the reason it is best to approach a horse close to the shoulder, and never to surprise a horse from the rear, or to reach first for the horse's mouth.

I am advised that while a horse is very sure- footed by nature, horses may accidentally step on an object such as a human's foot when the horse is balancing or turning around. When a horse is worked on unstable ground or slippery grass or footing, the horse could fall down injuring the horse, rider and /or handler.

Introduction to the Therapeutic and Learning Programs

Pearl Ranch, LLC, is an organization founded by Margot Luckman, M.S., C.R.C., L.C.P.C.,E. S., C.M./F. with the intent to promote growth and learning by offering clients an alternative to traditional talk therapy, and group learning with horses, by providing Equine Assisted Psychotherapy and Equine Assisted Learning.

Values

At Pearl Ranch LLC, the values that are important to us include:
The safety of all participants, human and animal;
Respect for all;
The courage to try new things without judging the outcome;
Cooperation and negotiation with others;
Personal growth and learning;
Balancing consistency and flexibility; and
Responsibility.
We believe that through the process of building relationships with animals and the natural environment an individual can come to know themselves better. This process also allows individuals to develop and improve communication with others and to manage the expression of feelings with greater clarity.

Goals

It is important to us that we provide a safe environment in which to:
Discover and nurture strengths, interests and talents;
Support effort toward change;
Establish consistent and stable relationships;
Improve interpersonal skills;
Enhance self-worth and empowerment;
Identify and develop individual learning styles;
Gain knowledge, communication and copying skills through outdoor experiences, and
Conduct Equine Assisted Psychotherapy (EAP) and Equine Assisted Learning (EAL).

Considerations

You will be introduced to safety aspects of being around animals during your initial sessions. Attention to safety issues by all involved will be a regular part of each session. If you are the parent/guardian of a program participant, your interest in the process and activities is important. Please notify the therapist/facilitator of any significant behavioral/emotional or physical changes, which may impact activities.

It is important for us to have an understanding of the participant's physical strengths and weaknesses. This information might include flexibility, hearing/sight impairments, endurance, balances, and allergies, skin sensitivities, cardiac problems, and dexterity. Please let us know of any problems, which arise during physical activities so that we may develop sessions accordingly.

We wish to keep participation in our program a productive experience for all.
Physical contact between participants does occur. It is our expectation that everyone (staff and participants) will maintain appropriate physical and personal boundaries.
Program participants should wear clothing suitable to being in a barn and animal oriented environment. We will assist you to meet this standard in any way we can. The therapist/facilitator will discuss the particulars of this with you prior to your first session. A session will not proceed if the participant's clothing is unsuitable.

Agreement:
I agree to be responsible for my physical, spiritual, mental and emotional safety, and in that way, add to the safety of all involved.

______________________________________ __________________
Participants Signature Date

______________________________________ __________________
Signature of Parent/Guardian if participant is a minor Date

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NOTICE OF PRIVACY PRACTICES

PURPOSE:

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

This notice takes effect on October 15, 2002 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION:

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal require ments. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notices of Changes to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we can use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. <u>We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.</u>

FOR TREATMENT:
We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you.

FOR PAYMENT:
We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS:
We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES:
In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Notification:

Medical information to notify or help notify:

- ☐ A family member
- ☐ Your personal representative
- ☐ Another person responsible for your care

We will share information about your location, general condition, or death. If you are present we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgement to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x ray or medical information about you.

Disaster Relief:

Medical information with public or private organization or person who can legally assist in disaster relief efforts.

Specialized Government Functions:

Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for The Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits

Court Orders & Judicial & Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpena, discovery request, or other lawful process, under certain circumstances, such as a court order, warrant, or grand jury subpoena, we may share limited information with law enforcement officials concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be a risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, Or Domestic Violence We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health and safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being a part of a crime or has escaped from legal custody.

Workers' Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers' compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You have a right to:

1. Look at or get copies of your medical information. You must make your request in writing. You may get the form to request access by using the contact information listed at this end of this notice. You may also request access by sending a letter to the attention of Medical Records. **If you request copies, we will charge you $1.50 for each page plus postage, if you want the copies mailed to you. If you want to pick up the copies, the first request is free of charge, but remaining requests for pick up will be at $1.50 per page.**
2. Receive a list of all times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain paper copy by making a request in writing to the contact person listed at the end of this notice.

QUESTIONS AND COMPLAINTS

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Certified Counseling Services, LLC
Margot Luckman
2305 Duncan Drive
Missoula, MT 59802
406-542-0820

If you think that we may have violated your privacy rights, contact the person named above. You may also submit a written complaint to the US Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.