HIPAA Notice of Privacy Practices

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

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your therapist, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing mental health care services to you, to pay your health care bills, to support the operation of the therapist's practice, and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your mental health care and any related service. This includes the coordination or management of your mental health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for psychological testing or a hospital stay may require that your relevant protected health information be disclosed to your health plan to obtain approval for the psychological testing or hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call you by name in the waiting room when your therapist is ready to see you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law; public health issues as required by law; communicable diseases; health oversight; abuse or neglect; food and drug administration requirements; legal proceedings; law enforcement; coroners, funeral directors, and organ donation; research; criminal activity; military activity and national security; workers' compensation; inmates; required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time in writing, except to the extent that your therapist or the therapist's practice has taken action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following is a statement of rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under Federal Law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.

ADULT INTAKE

Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

I have received a copy of my privacy rights under the Health Insurance Portability Act. I agree to all of these policies and I understand that I may contact this office to make any changes I require. I understand that if I sign via electronic signature, my consent is still considered valid.

Client Signature(s) - Required for Services _____ Date: _____

INFORMED CONSENT FOR PROFESSIONAL SERVICES AGREEMENT: My signature below indicates that I voluntarily agree to participate in the assessment and counseling as offered. I acknowledge that no guarantees have been made to me regarding the outcome of my therapy. I understand my rights and responsibilities as stated in this document. I acknowledge receipt of this document and all the information contained in this document along with the **HIPAA Privacy Practices**. I agree that my therapist may withdraw and will not be obligated to provide counseling services if I fail to abide by the terms specified in this document. **By my signature below**, I certify that I am not under a legal disability that prevents me from understanding the terms of this agreement, and I accept all the terms and conditions as herein stated.

It is understood and agreed that I as a client will never tape a session without the express written consent of the therapist. Any acts to tape a session without the knowledge of the therapist invalidates the client/therapist relationship contracted herein.

Emergency Situations

Counseling services are provided on an outpatient basis and this office is only set up to accommodate individuals who are reasonably safe and resourceful. If at any point you do not feel like this is sufficient support, inform your counselor and discuss additional resources or a transfer to more intensive services. If you have a mental health emergency, we encourage you to do one of the following: • Go to your nearest emergency room • Call 911

Client Signature(s) - Required for Services _____ Date: _____