

NOTICE OF PRIVACY PRACTICES

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

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our 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. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

What is Protected Health Information?

Information may be collected about your past, present mental health or health, the treatment or other services you received from this program or from others, or about payment for your health care. The information that is collected is called, PHI, which stands for Protected Health Information. This information goes into your file that is kept in this office. This file of Protected Health Information (PHI) is likely to include these kinds of information:

- Your history, including family, health, educational, vocational, and personal history Reasons you came for treatment, including problems, symptoms, needs, goals

- Diagnoses

- A treatment plan, including goals and strategies for your care

- Progress notes, which include the content of our discussion in therapeutic sessions

- Records received from others who treated or evaluated you, including psychological test scores, school records, etc.

- Information about medications, current or past Billing and insurance information, if applicable other information pertinent to your care

The information collected will be used for purposes of:

- To plan your care and treatment

- To decide how well treatment is working for you

- When, with your informed consent and authorization, I talk with other healthcare professionals who are also treating you such as your family doctor or the professional who may have referred you to me

- To show that you actually received the services from this program for purposes of billing third party pay, if applicable

Although your health record is the physical property of this office, you have a right to look at or obtain a copy of health information, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If you find anything in your records that you think is incorrect or something important is missing, you can ask me to amend your record by submitting a written request. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

How your protected health information (PHI) can be used and shared:

When your information is reviewed by me that is called, in the law, “use”. If the information is shared with or sent to others outside this office, that is called, in the law, “disclosure”. When your protected health information (PHI) is disclosed to others, only the minimum necessary protected health information (PHI) is shared. When your PHI is disclosed to others, your consent and a written authorization form must be signed by you. If you choose to permit this office, however, I am required by federal, state, or local laws to make some disclosures without your consent or authorization as explained below:

I have to report suspected child abuse and suspected abuse of vulnerable adults.

If you are involved in a lawsuit or legal proceeding and I receive a subpoena, discovery request, or other lawful process, I may have to release some of your protected health information.

I have to disclose some information to the government agencies which check on me to see that I am obeying the privacy laws.

If I believe there is a serious threat to your health or safety or that of another person or the public, I will disclose some of your protected health information. I will do this in compliance with existing state and federal laws.

An accounting of disclosures:

I will keep an accounting of disclosures of your PHI in your record.

When written Release of Information forms are signed, you have the right to rescind this release at any time. This rescind request must be made in writing directly to this therapist.

It is our hope that these procedures will protect your rights and privacy. If you have any questions please ask for clarification. You are entitled to a copy of these policies upon request. If there are further questions, please write to:

Dept. of Health and Human Services, 200 Independence Ave. SW., Room 509F, HHH Building, Washington, DC, 20201.

I acknowledge receipt of the Notice of Privacy Practices.

Signature of Client

Date