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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 IT CAREFULLY.

INTRODUCTION

I understand that medical information about you and your health is personal. I am committed to protecting medical information about you. I have created or will create a record of the care and services you have received from me. I need this record to provide you with quality care and comply with certain legal requirements. Accordingly, the Notice of Privacy Practices applies to all of the records of your care generated by any health care practitioner in this facility.

This Notice of Privacy Practices describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment of 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.

CHANGES TO THIS NOTICE

I reserve the right to make changes to the notice of privacy practices as allowed by law. If and when this notice of privacy practices changes, I will post a copy in my office in a prominent location. I will also provide you with a copy of the revised notice of privacy practices upon your request

ACKNOWLEDGEMENT

YOU WILL BE ASKED TO SIGN AN ACKNOWLEDGEMENT TO SHOW THAT YOU HAVE RECEIVED THIS NOTICE OF PRIVACY PRACTICES.

USE AND DISCLOSURES

I will use and disclose elements of your protected health information (“PHI”) for treatment, payment (except as noted below) or health care operations without your consent or authorization. The examples included in each category do not list every type of use or disclosure that may fall within that category.

TREATMENT

I will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. While I do not accept insurance, nor transmit any forms electronically this may apply to your health care with a third party. For example, I would disclose your protected health information, as necessary 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, should you ask a family member to make payment, I might need to discuss the date(s) of your visit(s). I will not furnish your medical record or discuss your medical condition with anyone without your written authorization.

HEALTHCARE OPERATIONS

I may use or disclose, as needed, your protected health information in order to support the business of operation. I may use a sign-in sheet at the registration desk where you will be asked to sign your name, your therapist and indicate your time of arrival. I may also call you by name in the waiting room when I am ready to see you. I may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

AS REQUIRED BY LAW

I will disclose medical information about you when required or authorized to do so by federal, state or local law. I may use or disclose your protected health information in the following situation 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 mush 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

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 my office has taken an action in reliance of the use or disclosure indicated in the previously signed authorization.

YOUR RIGHTS

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

You have the right to request a restriction of your protected health information. This means you may ask me not to use or disclose any part of your protected health information for the purposes 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 the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction that you may request. If I believe 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 me by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from me. upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your therapist amend your protected health information. If I deny your request for amendment, you have the right to file a statement of disagreement with me and I 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 I have made, if any, of your protected health information.

I reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints. You may complain to me or to the Secretary of Health and Human Services if you believe your privacy right have been violated. You may file a complaint with me by notifying me of your complaint. I will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 13, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please let me know. Signature below is only acknowledgment that you have received this Notice of Privacy Practices.

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Print Name of Client Acknowledging Receipt of Privacy Practices

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Client Signature or Parent/Legal Guardian Signature of Minor Date