

NOTICE OF PRIVACY PRACTICES

AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) 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.

Our commitment to your privacy:

This practice is dedicated to maintaining the privacy of your individually identifiable health information (or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time. The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in a visible location at all times, and you may request a copy of our most current Notice at any time. **If you have questions about this Notice**, please contact your counselor.

Your PHI may be used or disclosed in the following ways:

Treatment: This practice may use your PHI to treat you. For example, the people who work for the practice may use or disclose your PHI in order to treat you. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents. We may also disclose your PHI to other health care providers for purposes related to your treatment. Finally, this practice may use and disclose your PHI to inform you of potential treatment options or alternatives, or of health-related benefits or services that may be of interest to you.

Payment: This practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use your PHI to bill you directly for services and items.

Optional Appointment Reminders: This practice may use and disclose your PHI to contact you and remind you of an appointment if you have checked the appropriate box next to the telephone number on the fact sheet.

Disclosures About Child Abuse: If, in our professional capacity, we know or suspect that a child under 18 years of age or an intellectually impaired, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of nature that reasonably indicates abuse or neglect, we are required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or a municipal or county peace officer.

Disclosures Adult or Domestic Abuse: If we have reasonable cause to believe that an adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, we are required by law to immediately report such cases to the County Department of Job and Family Services.

Serious Threat to Health or Safety: If we believe that you pose a clear and substantial risk of imminent serious harm to yourself or another person, we may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to us an explicit threat of imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and we believe you have the intent and ability to carry out the threat, then we are required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat b) your identity, and c) the identity of the potential victim(s).

As Required By Law: We will disclose PHI when required to do so by federal, state, or local law.

Your rights regarding your PHI:

Confidential Communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to your counselor specifying the requested method of contact, or the location where you wish to be contacted. This practice will accommodate reasonable requests. You do not need to give a reason for your request.

Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to your counselor. Your request must describe in a clear and concise fashion 1) the information you wish restricted 2) whether you are requesting to limit our practice's use, disclosure, or both 3) To whom you want the limits to apply.

Inspection and copies: You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to counselor in order to inspect and/or obtain a copy of your PHI. This practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. This practice may deny your request to inspect and/or copy in certain limited circumstances.; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by our practice. To request an amendment, your request must be made in writing and submitted to your counselor. You must provide us with a reason that supports your request for amendment. This practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion 1) accurate and complete 2) not part of the PHI kept by or for the practice 3) not part of the PHI which you would be permitted to inspect and copy or 4) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures: All of our clients have the right to request an "accounting of disclosure" which is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the billing department using your information to file our insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to your counselor. All requests for an "accounting of disclosure" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of this Notice: You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact your counselor.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with Supervision or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to provide an authorization for other uses and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care. Again, if you have any questions regarding this notice or our health information privacy policies, please contact your counselor.

Received:

Client Signature _____ Date _____