

Advanced Trauma Recovery & Mental Healthcare, LLC

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NOTICE OF PRIVACY PRACTICES

Health Insurance Portability Accountability Act (HIPAA) Client Rights & Therapist Duties

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

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

I. MY PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information (“PHI”) that identifies you is kept private, outside of the “Limits to Confidentiality” described below.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

II. LIMITS TO CONFIDENTIALITY: The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by law. I cannot provide any information without your (or your legal guardian's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider. . Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
5. Appointment reminders and health related benefits or services. I may use PHI to provide appointment or other administrative reminders or give you information about treatment alternatives, or other health care services or benefits I offer.
6. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
7. To a coroner or medical examiner (e.g., for identification or cause of death)
8. For specialized government functions such as fitness for military duties, eligibility for VA
9. There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:
10. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the appropriate agency of Virginia. Once such a report is filed, I may be required to provide additional information.
11. If I know or have reasonable cause to suspect that an older or vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the appropriate

agency of Virginia. Once such a report is filed, I may be required to provide additional information.

12. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.
13. For Treatment, Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may use and disclose your health information internally in the course of your treatment. Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.
I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. I may use and disclose your health information as part of our internal operations, such as a review of records to assure quality. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
14. Psychotherapy Notes. I may keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is: For my use in treating you; For my use in defending myself in legal proceedings instituted by you; For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA; Required by law and the use or disclosure is limited to the requirements of such law; Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes; and/or Required to help avert a serious threat to the health and safety of others.

III. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. *Right to Request Limits on Uses and Disclosures of Your PHI* – You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care or as required by law.
2. *Right to Release Information with Written Consent* – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.
3. *Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full* – You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full. I will agree to such unless a law requires us to share that information.

4. *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail/email to a different address, and I will agree to all reasonable requests.
5. *Right to Inspect and Copy* – Other than “psychotherapy notes,” you have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
6. *Right to Treatment* – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
7. *Right to Choose Someone to Act for You* – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
8. *Right to Choose & Terminate* – You have the right to decide not to receive services with me. You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
9. *Right to Get a List of the Disclosures I Have Made* – You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
10. *Right to Amend* – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
11. *Right to a Copy of This Notice* – You have the right to get a copy of this Notice. Even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

IV) COMPLAINTS: If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the Virginia Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

V) ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.