**NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL (INCLUDING MENTAL HEALTH) INFORMATION ABOUT YOU MAY BE USED AND DISCLOSES AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY!

During the process of providing services to you, I will obtain, record, and use mental health and

medical information about you that is protected health information. Ordinarily that information is

confidential and will not be used or disclosed, except as described below.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. General Uses and Disclosures Not Requiring the Client’s Consent. I may use and

disclose PHI about you without your authorization in the following circumstances:

1. Treatment. Treatment refers to the provision, coordination, or management of health care

and related services by one or more health care providers. For example, I may use your

information to plan your course of treatment and to consult with another health care provider to

ensure the most appropriate methods are being used to treat you.

2. Payment. Payment refers to the activities undertaken by a health care provider to obtain or

provide reimbursement for the provision of care. I may use and give your information to others

to bill and collect payment for the treatment and services provided to you. For example, I may

share portions of your information with billing services and billing personnel, collection services,

insurance companies, health plans, and third party payers which provide you coverage. The

information provided to insurers and other third party payers may include information that

identifies you, as well as your diagnoses, type of service, date of service, provider name/

identifier, and other information about you condition and treatment. If you choose to pay out-of-pocket in full at the time of you appointment, then you have the right to restrict your private health information from your health plan.

3. Health Care Operations. Health Care Operations refers to activities that are regular

functions of the management and administrative activities. For example, I may use your health

information in monitoring of service quality, training and education, medical reviews, legal

services, auditing functions, compliance programs, business management and general

administrative activities, and planning for future operations.

4. Contacting the Client. I may contact you to remind you of appointments and to tell you

about treatments or other services that might be of benefit to you.

5. Required by Law Disclosure. I will disclose protected health information when required

by law. This includes, but is not limited to the following situations:

 Reporting child abuse or neglect;

 When the disclosure is for judicial and administrative proceedings, for example in

response to an order of a court or administrative tribunal;

 When there is a legal duty to warn or take action regarding imminent danger of others;

 When the client is a danger to self or others or gravely disabled;

 When required to report certain communicable diseases and certain injuries;

 When a Coroner is investigating the client’s death;

 To government regulatory and oversight agencies which are authorized by law to

oversee my operations.

6. Crimes. Crimes on the premises of the office or observed by myself or are directed toward myself, will be reported to law enforcement.

7. Business Associates. Some of the functions of the health care providers are provided by

contracts with business associates. For example, some clinical, quality assurance, legal,

auditing, and practice management services may be provided by contracting with outside

entities to perform these services. In those situations, protected health information will be

provided to those contractors as is needed to perform their contracted tasks. In those situations, the business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

8. Research. I may use or disclose protected health information for research purposes if the

relevant limitations of the Federal HIPAA Privacy Regulations are followed. 45CFR §164.512(i).

9. Involuntary Clients. Information regarding clients who are being treated involuntary will be

shared with other treatment providers, legal entities, and others, as necessary to provide the

care and management coordination needed.

10. Family Members. Except for certain minors, incompetent clients, or involuntary clients,

protected health information cannot be provided to family members without the client’s consent.

In situations where family members are present during a discussion with the client, and it can be

reasonably inferred from the circumstances that the client does not object, information may be

disclosed in the course of that discussion. However, if the client objects, protected health

information will not be disclosed.

11. Emergencies. In life threatening emergencies, I will disclose information necessary to

avoid serious harm or death.

B. Client Authorization or Consent. I may not use or disclose protected health information in

any other way without a signed Authorization or Release of Information. This includes requiring a signed Authorization or Release of Information prior to PHI being used for marketing or sale purposes. When you sign an Authorization or Release of Information, it may later be revoked, provided that revocation is in writing. The revocation will apply except to the extent that I have already relied on it.

C. Psychotherapy Notes. I maintain psychotherapy notes separately from the remainder of my

records. Use or disclosure of these notes will only occur under these circumstances: (a) you

specifically authorize their use or disclosure in a separate written authorization; (b) I use them

for your treatment; (c) I may use them for my own training programs (but will change your name

to protect your privacy) in which students, trainees, or practitioners in mental health learn under

supervision to practice or improve their skills in group, joint, family or individual counseling; (d) if you bring a legal action and I have to defend myself; and (e) certain limited circumstances

defined by law.

II. YOUR RIGHTS AS A CLIENT

A. Additional Restrictions. You have the right to request additional restrictions on the use or

disclosure of your health information. I am not required to agree to your request, and there are

certain limits to any restriction, which will be provided to you at the time of your request. To

exercise your right discuss with me.

B. Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of protected health information by alternative means or alternative locations. For example, if you do not want to receive bills or other materials at your home, you a request that this information be sent to another address. To exercise this right discuss with me.

C. Access to Protected Health Information. You have a right to inspect and obtain a copy of

the protected health information contained in clinical, billing and other records used to make

decisions about you. Your request must be in writing. I may charge you related fees. There are

some limitations to this right, which will be provided to you at the time of your request, if any

such limitation applies. To exercise this right discuss with me.

D. Amendment to Your Record. You have the right to request amendment of you protected

health information. Your request must be in writing and it must explain why the information

should be amended. I am not required to amend the record if it is determined that the record is

accurate and complete. There are other exceptions, which will be provided to you at the time of

your request, relevant, along with the appeal process available to you. To exercise this right

discuss with me.

E. Accounting of Disclosures. You have the right to receive an accounting of certain

disclosures I have made regarding your protected health information. However, that accounting

does not include disclosures that were made for the purpose of treatment, payment, or health

care operations. In addition, the accounting does not include disclosures made to you, disclosures authorized by you, or disclosures made prior to January 1, 2009. There are other exceptions that will be provided to you, should you request an accounting. To exercise this right discuss with me.

F. Fundraising Communications: You have the right to opt out of any fundraising communications offered through this organization.

G. Copy of the Notice. You have a right to request a paper copy of this Notice at any time.

III. ADDITIONAL INFORMATION

A. Privacy Law. I am required by law to maintain the privacy of your protected health

information. I am also required to provide clients with notice of my legal duties and privacy

practices with respect to protected health information. That is the purpose of this notice.

B. Terms of the Notice. I am required to abide by the terms of this Notice, or any amended

Notice that may follow. You will be notified if there is a breach of unsecured PHI.

C. Changes to the Notice. I reserve the right to change my privacy practices and the terms of

this Notice at any time, and to make the new Notice provisions effective for all protected

health information that I maintain. When changes are made, the revised Notice will be

posted in my office. Copies of this Notice will be available upon request.

D. Complaints Regarding Privacy Rights. If you are concerned that I have violated your

privacy rights, you may file a complaint with me directly, in writing, using the contact information provided at the end of this Notice. You also have the right to complain to the United States Secretary of Health and Human Services, 200 Independence Avenue, SW, Room 515F, HHH Bldg, Washington, DC 20201. It is my policy that there will be no retaliation for your filing such a complaint.

E. Effective Date. This Notice is effective December 1, 2014.

F. Additional Information. If you want more information about my privacy practices or have any questions or concerns, please contact me directly.

G. Contact: Water’s Edge Counseling

2103 Bull Street

Savannah, GA 31401

**ACKNOWLEDGEMENT OF NOTICE**

**OF PRIVACE PRACTICES**

It is required by Federal Law to provide clients with the Notice of Privacy Practices. This Notice describes how medical (including mental health) information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I acknowledge that I have been given a copy of the Notice of Privacy Practices.

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Client’s Signature (Parent/Guardian) Date

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Therapist’s Signature Date

If client refuses to sign an acknowledgment, mark the appropriate box below:

\_\_\_\_ Client refused to accept Notice of Privacy Practices and refused to sign ACKNOWLEDGMENT.

\_\_\_\_\_Client accepted Notice of Privacy Practices but refused to sign ACKNOWLEDGMENT.

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Name of Client Date Notice was offered

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Therapist’s Signature Date