

## **NOTICE OF PRIVACY PRACTICES**

**As required by the Health Insurance Portability and Accountability Act (HIPAA)**

*This Notice describes how medical and other information about you may be used and disclosed and how you can get access to this information. Please read it carefully.*

The privacy and confidentiality of your health information is very important and we are committed to protecting it to the extent we can, consistent with law and ethical standards. Your health information includes records that we create and obtain in order to provide care to you. For example, it includes a record of your counseling, any referrals made, bills, insurance claims and other payment information. You have a right to know how we use and share your personal information. This Notice tells you our responsibilities and your rights.

Hope Counseling, Inc. provides services to residents of Florida. In order to provide you with the best possible care, employees involved in the operations of this practice may have access to your records. All employees of this practice follow these Privacy Policies.

### **Confidential Records**

The personal information you give us goes into a confidential (private) written record. We use it to plan for your counseling services and to receive payment for those services from our funding sources. Usually we must have your permission to use or share your personal information. Sometimes, for example, in safety situations we may share it without your permission. This is further described below. The permanent record is kept on paper. We will keep this for at least 7 years after you stop receiving services, and then your record will be destroyed. Some records and billing information may also be stored in computers as well.

### **Our Responsibilities**

- ◆ We will keep your information private
- ◆ We will follow these Privacy Practices
- ◆ We will give you a copy of our Notice of Privacy Practices
- ◆ If our Privacy Practices change, we will give you a new copy at your next scheduled appointment or whenever you request one.

### **How We Use and Share Your Personal Information**

There are three ways we use and share information about you. The three ways are to provide:

#### **1. Services, with your consent**

When you apply for services, you are asked to sign Consent for Treatment form. With this consent, we can use and share information about you in these ways:

*a. For Treatment and Services*

We may use and share information about you with professionals and agencies who serve you. For example, we may use information about you during professional supervision/consultation so that we can ensure that you are getting the best services we can provide.

*b. For Payment*

We may use and share information about you to obtain payment for services we have provided to you. For example, we may give information to those agencies that provide funding (i.e. victim's assistance) or to seek approval for payment from your insurance company.

#### **2. Provide information to others who need it, with your approval**

If we need to share personal information about you for other reasons, we will ask you to sign an Authorization Form to give your approval. This will tell you what information we need to share, who will receive it, and why. For example, you need to sign an Authorization Form for us to share information with your child's school if you want us to talk with the teacher. Your approval is only good until the date stated on the form, not forever. If you change your mind, tell us in writing and we will no longer share the information.

#### **3. Provide information to others who need it, without your consent or approval**

We may sometimes share personal information about you without your approval. We will do this only when it is lawful and will not share any more information than necessary. The Department of Health and Human Services requires us to list specific situations in which one's personal information might be released.

- ◆ **Appointments** – for appointment reminders or notification when an appointment must be cancelled or rescheduled.
- ◆ **Emergency Treatment** – when you need medical care in a crisis.
- ◆ **Health and Safety** – to prevent or reduce a serious threat to someone's health or safety. We will do what is necessary to protect you and others.
- ◆ **Oversight** – when we are reviewed by licensing and accreditation agencies or auditors.
- ◆ **Legal Proceedings** – in response to court orders and other legal actions.
- ◆ **Law Enforcement** – if you are missing or in danger. Law enforcement may have access to your information for legal or civil proceedings.
- ◆ **Abuse or Neglect** – to report suspected abuse, neglect or exploitation of any child or vulnerable adult.
- ◆ **Government** – to government regulatory agencies, including national security and intelligence agencies.
- ◆ **Required by Law** – at other times when the law requires releasing information.
- ◆ **Public Health** – to report diseases, drug reactions or other public health concerns.
- ◆ **Funeral Directors** – to the funeral director who will take care of your body.
- ◆ **Organ Donation** – for organ, eye or tissue donation purposes.
- ◆ **Coroners** – to a coroner or medical examiner for identification or other purposes.
- ◆ **Workers' Compensation** – to process a Workers' Compensation claim.

### **Your Rights**

You have a right to read your record and to have a copy of its contents or a summary report. We will charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied. You may request review of the denial by another licensed mental health professional and we will comply with the outcome of that review. You have the right to correct information in the record that you believe is inaccurate by providing a correction statement.

You have the right to request that certain information not be shared, although Hope Counseling, Inc. is not required to follow your request. If we agree, we will comply with your request unless the information is needed for an emergency.

You have the right to confidential communications. You may request that we communicate with you in a certain way or at a certain location. For example, you may want us to only contact you at home and not at your place of employment. This request needs to be made in writing. We will make every effort to accommodate your request as long as it is reasonable. We may request that you give us an alternative means to reach you, especially if there is an emergency. If we are unable to contact you using your requested means, we may contact you using any information we have.

You have the right to receive a list of the disclosures of your personal information that have been made for reasons other than for treatment or healthcare operations. You must state the time period for which you wish to receive this information, which may not be longer than six years and not begin sooner than the date of signature.

You have the right to refuse certain types of treatment or services. This practice will be happy to give you proper referrals should you wish to obtain treatment elsewhere.

We will not use your personal information for any marketing purposes. We would only use your photo or comments in any of the practice's materials (brochures, videos, etc.) with your written permission. At times, we have asked participants to appear with us at public forums but your refusal to do this would not impact your receiving services with Hope Counseling, Inc.

If you believe your privacy rights have been violated, you may file a complaint with Hope Counseling, Inc. or with the HHS Office of Civil Rights. You will not be penalized for making a complaint. If you have any questions, would like to request restrictions on uses and disclosure for health care treatment or operations, or would like to file a complaint, please contact Hope Counseling, Inc. at (772) 429-3334.

Your signature on the Acknowledgement Form does not indicate your agreement with the information provided. It simply acknowledges that you have received and read Hope Counseling, Inc.'s Notice of Privacy Practices.

## **Acknowledgement of Notice of Privacy Practices**

**Hope Counseling, Inc.**

130 South Indian River Drive, Suite 301, Fort Pierce, FL 34950 (772) 429-3334 Fax (772) 429-3336

Name: \_\_\_\_\_ DOB \_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_

**I acknowledge that I have received a copy of the Notice of Privacy Practices of Hope Counseling, Inc. effective the date of signature.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date