

**Notice of Privacy Practices**

<b>Client Name</b>	<b>Client Name</b>
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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT CLIENT(S) MAY BE USED AND DISCLOSED AND HOW CAN YOU GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Goals and Outcomes**

Generally, counseling is most useful in helping individuals help themselves or improve their relationships by changing feelings, thoughts, and/or behaviors. You and/or your child determine the nature and amount of change that will be made.

**Benefits and Risks**

Most people experience improvement or resolution to the concerns that brought them to counseling, but of course, there are no guarantees; and there are some risks. For example, counseling could open up new levels of awareness that may cause discomfort.

**Emergencies**

Emergency situations may arise when you may need to speak with me by telephone between appointments. Being a practitioner in a solo practice limits my ability to respond to such emergencies in a timely manner. You are entering a counseling relationship with this understanding and are accepting the level of service I can provide with the implied limitations. Specifically, when I am unavailable for any reason, it will be your decision to wait for a return call, which could take several days, or assume the responsibility of finding an alternative source of assistance. Please be advised that there will be a fee charged for any phone call returned to discuss anything other than the changing of appointment times. These telephone consultations are billed at the rate of \$30 per fifteen minutes.

**My commitment to your privacy**

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private. These laws are complicated, but I must give you this important information. This is a shorter version of the full notice of privacy practices. If you would like a full copy of this notice, please let me know and I will provide it at your request.

**How I use and disclose your protected health information with your consent**

I will use the information I collect about you mainly to provide you with treatment, to arrange payment for my services, and for some other business activities that are called, in the law, health care operations. After you have read this notice I will ask you to sign a consent form to let me use and share your information in these ways. If you do not consent and sign this form, I cannot treat you. If I want to use or send, share, or release your information for other purposes, I will discuss this with you and ask you to sign an authorization form to allow this.

**Disclosing your health information without your consent**

There are some times when the laws require me to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. I will only share information with persons who are able to help prevent or reduce the threat.
2. When I am required to do so by lawsuits and other legal or court proceedings.

3. If a law enforcement official requires me to do so.
4. For workers' compensation and similar benefit programs.
5. In the event of abuse/neglect reported to me that involves a child, the elderly, the disabled or other situations for which I am a mandated reporter.

There are some other rare situations. They are described in the longer version of my notice of privacy practices.

**Your rights regarding your health information**

1. You can ask me to communicate with you in a particular way or at a certain place that is more private for you. For example. You can ask me to call you at home, and not at work, to schedule or cancel an appointment. I will try my best to do as you ask.
2. You can ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information I have about you, such as your medical and billing records. You can get a copy of these records, but there may be a charge. Contact me to arrange how to see your records.
4. If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation. You have to make this request in writing. You must also tell me the reasons you want to make the changes.
5. You have the right to a copy of this notice. If I change this notice, I will provide you with a copy of the new version.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the healthcare I provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. I will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or my health information privacy policies, please let me know.

The effective date of this notice is January 1, 2018.

Client/Parent Name Printed	Client/Parent Signature	Date
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