

# **Notice of Privacy Practices**

(HIPAA)

**This notice was created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Effective Date of this Notice: January 1, 2007. It describes how health information about you as a client of this practice may be used and disclosed and how you can get access to your health information. Please review it carefully.**

Our practice is dedicated to maintaining the privacy of your Protected Health Information (PHI). In conducting business, we will create records regarding your treatment and the services provided to you.

We reserve the right to revise or amend this Notice of Privacy Practices, and any changes will be effective for all your records created since January 1, 2007, and for any records created in the future. We will post a copy of our current Notice in a visible location within the office, and you can request a copy of our current Notice at any time.

## **I. We may use and disclose your protected health information (PHI) in the following ways, for treatment, payment, and healthcare operations.**

- **Treatment.** We may use or disclose your PHI for purposes of coordinating or managing your health care and other services related to your health care. Examples of coordinated treatment include consulting with another health care provider, such as a physician, psychiatrist, nutrition specialist, or another therapist. In these situations, where you are not receiving direct treatment with another health care provider, we will make every effort to avoid revealing your identity.
- **Payment.** We may use and disclose your PHI in order to bill and collect payment for the services you receive from us. For example, we may contact your health insurer to certify what mental health benefits you are eligible for and what your coverage plan is, and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We may also use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items.
- **Appointment Reminders.** We may use or disclose your PHI to contact you and remind you of an appointment. If we receive your voice mail, we will leave our name, number, and appointment information, but will not reveal what the appointment concerns.
- **Release of Information to Family/Friends.** We may disclose information about you to persons who are involved in your care or payment for your care, such as family members, relatives, or close personal friends unless otherwise specified. Any such disclosure will be limited to information directly related to the person's

involvement in your care. We will contact person(s) you listed as your emergency contact and/or who answer your home phone number. If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable, for example, because you are incapacitated or because of some other emergency circumstance, we will use our professional judgment to determine what is in your best interest regarding any such disclosure.

- **Health Care Operations** are activities that relate to the performance and operation of our practice. We may share health information about you with business associates who are performing services on our behalf. For example, we may contract with a company to service our computer, do our billing, and provide answering and check-in service. Our business associates are obligated to safeguard your health information. We will share with our business associates only the minimum amount of personal health information necessary for them to assist.
- **Disclosures Required by Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law. We will obtain authorization (written permission) from you for any release of information beyond the general consent for the above listed specific disclosures. You may revoke all such authorizations at any time, provided each revocation is in writing.**

## II. Use and disclosure of your PHI in certain special circumstances.

The following categories describe unique situations in which we may use or disclose your health information *with neither consent nor authorization.*

- **Child Abuse.** If you give us information that leads us to suspect child abuse, neglect, or death due to maltreatment, we must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, we must do so.
- **Adult and Domestic Abuse.** If information you provide us gives us reasonable cause to believe that a disabled adult is in need of protective services, we must report this to the Director of Social Services.
- **Health Oversight Activities.** We may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights and the health care system in general.
- **Judicial or Administrative Proceedings.** If you are involved in a court proceeding, and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is privileged under state law, and we must not release this information without your

written authorization, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety.** We may disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
- **Workers' Compensation.** We may release your PHI for workers' compensation and similar programs when required by law.
- **Minors.** If you are an un-emancipated minor under North Carolina law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting in loco parentis, in accordance with legal and ethical responsibilities.
- **Notification.** We may notify a family member or other person you have noted as emergency contact of your general condition. If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable, for example, because you are incapacitated, we cannot reach you at your home or work number for several days, or because of some other emergency circumstance, we will use our professional judgment to determine what is in your best interest regarding any such disclosure.
- **Parents.** If you are a parent of an un-emancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care from us, we may disclose health information about your child to you. In some circumstances, we may not disclose health information about an un-emancipated minor to you. For example, if your child is legally authorized to consent to treatment (without separate consent from you), consents to such treatment, and does not request that you be treated as his or her personal representative, we may not disclose health information about your child to you without your child's written authorization.
- **Personal Representative.** If you are an adult or emancipated minor, we may disclose health information about you to a personal representative authorized to act on your behalf in making decisions about your health care.

### III. Psychotherapy Notes

For every client that participates in therapy, we create three files: a billing file, a general medical record file, and a psychotherapy note file. These files are stored in a locked filing cabinet and will be kept for six years from the beginning date of therapy. Another appointed licensed health care professional or our licensing board will be in charge of handling the files if your personal provider should become incapacitated.

We will keep separate notes during the course of your therapy sessions about our conversations. These notes are kept apart from the rest of your medical records and are not available to anyone. You cannot be required to authorize the release of your psychotherapy notes to obtain health-insurance benefits for your treatment, or enroll in a health plan. Psychotherapy notes are also not among the records that you may request to review or copy.

Your medical records include basic information, such as your medication treatment record, counseling session start and stop times, the types and frequencies of treatment you receive, and your test results. They also include a summary of your diagnosis, condition, treatment plan symptoms, prognosis, or treatment progress. Medical records may be disclosed by a therapist only after you have given written authorization to do so, with limited exceptions, which have been explained in detail in Section II.

#### **IV. Your Rights Regarding Your Personal Health Information (PHI)**

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

**2. 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 and describe in a clear and concise fashion a) the information you wish restricted; b) whether you are requesting to limit our practice's use, disclosure or both; and c) to whom you want the limits to apply.

**3. 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 in order to inspect and/or obtain a copy of your PHI. We may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. We may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial by another licensed health care professional chosen by us.

**4. 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 or for our practice. To request an amendment, your request must be made in writing and submitted to us. You must provide us with a reason that supports

your request for amendment. We 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: a) accurate and complete; b) not part of the PHI kept by or for the practice; c) not part of the PHI which you would be permitted to inspect and copy; or d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

**5. Accounting of Disclosures.** All our clients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine client care is not required to be documented; for example, routine sharing of information with billing services, using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to us.

All requests for an “accounting of disclosures” 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 January 1, 2006. The first list you request within a 12-month period is free of charge, but we may charge you for additional lists within the same 12-month period. We will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

**6. Right to a Paper copy of This Notice.** You are entitled to receive a paper copy of this notice of privacy practices. You may ask us to give you a copy of this notice at any time.

**7. Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us 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.

**8. Right to Provide an Authorization for Other Uses and Disclosures.** We 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 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. If you have any questions regarding this notice of health information privacy policies, please contact us at (910) 814-2197.

Client Name \_\_\_\_\_

Record Number \_\_\_\_\_

**Client Consent for Use and Disclosure of Protected Health Information  
And Written Receipt**

I hereby give our consent to use and disclose protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). The Notice of Privacy Practices provided by Peace of Mind, Inc. gives a more complete description of such uses and disclosures.

I have the right to review and receive the Notice of Privacy Practices prior to signing this consent. Peace of Mind, Inc. reserves the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices can be obtained by forwarding a written request to:

**Peace of Mind, Inc.**  
817 West Front Street  
P.O. Box 2088  
Lillington, NC 27546-2088

With this consent, Peace of Mind, Inc. may mail to our home or other alternative location any items that assist the practice in carrying out TPO. I am aware that this practice is not required to agree to our restrictions. However, if it does agree to our restrictions, it is bound by the agreement.

By signing this form, I am consenting to Peace of Mind, Inc.'s use and disclosure of our PHI to carry out TPO. I may revoke our consent in writing except to the extent that the practice has already made disclosures in reliance upon our prior consent. If I do not sign this consent, or later revoke it, Peace of Mind, Inc. may decline to provide treatment to me.

Further, I have been offered a written copy of this notice of privacy practices.

\_\_\_\_\_  
Signature of Client or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Client or Legal Guardian