NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DEISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

My commitment to your privacy:

This practice is dedicated to maintaining the privacy of your personal health information. As a professional, I am also required by law to do this. This hand-out is a summarized version of the full, legally required NPP which I keep in my office. If at any time you would like to review the more complete version, I will be glad to share it with you.

 In short, I will use any information about your health which I get from you or from others mainly to provide you with treatment, to arrange payment for my services or for some other business activities which are called in the law, health care operations. After you have read this NPP, please sign your name on the Consent signature line on the following page, enabling me to appropriately use and share information. If you do not consent and sign this form, I cannot treat you.

 If any information obtained from you or about you is needed for any reasons other than those specified, I will ask you to complete and sign a separate Authorization form.

 Your health information will be kept private, with the following legal exceptions:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization who is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires me to do so.
4. For Workers Compensation, your insurance company or similar benefit programs.

This list is not exhaustive. There are some other infrequent situations which may require release of information. They are described in detail in the longer version of the NPP.

Your rights regarding your health information;

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place. 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 have the right to ask me to limit what I tell certain individuals involved in your care or the payment for your care, such as family members and friends. While I don’t have to agree to your request, if I do agree, I will keep our agreement except when it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information I have about you such as your medial or billing records. You may even get a copy of these records, but I may charge you. Please note that although I keep detailed records of when we have had sessions and records of billing, I do not keep therapeutic notes for every session.
4. If you believer the information in your records is incorrect or incomplete , you can ask me to make some kind of changes to your health information. This request must be made in writing and must be accompanied by your reasons for the desired changes.
5. You have the right to a copy of this notice. If I change this NPP< I will make the revision available to you.
6. You have the right to file a complaint if you believe your privacy right s have been violated. You can file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

If you have questions regarding this notice or the health information privacy policies, please do not hesitate to ask.

Consent

I have read and understand the privacy regulation and my right as a client of this practice. I understand that the longer version of the NPP is available to me at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date