ELINOR BAWNIK
LMFT

NOTICE OF PRIVACY PRACTICES

I am obligated by law to provide you with this notice, which describes how medical-and mental-health information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

Introduction

I seriously respect my legal obligation to safeguard any confidential information that identifies you, including what is referred to as your protected health information, or PHI. I am legally required to protect the privacy of your confidential information, which includes information that I have created or received about your past, present, and/or future physical and mental health or condition. Your PHI likewise may include information regarding the provision of health-and mental-health care to you and the payment for this care. I am, likewise, required to explain to you how I might “use” and “disclose” your confidential information.

A “use” of your confidential information occurs when I share, examine, utilize, apply or analyze such information within the confines of my Psychology practice. A “disclosure” of your confidential information occurs when such is released, is transferred, has been given to, or is otherwise divulged to a third party outside of my private practice.

I may need to use or disclose your confidential information for a variety of reasons. For some of these uses or disclosures, I will need your prior written authorization. For others, however, your written authorization is not required. Below are categories of both.

Uses of disclosures that require your consent

I will ask you to sign a consent form allowing me to use and disclose your confidential information for purposes of your treatment and payment for such treatment.
I will ask that you sign a consent form allowing me use of your confidential information necessary for treatment purposes when, for example, I believe it is in your best interest for me to consult with your psychiatrist, general physician, or helping others regarding your medical-and mental-health care.

Uses and disclosures that do not require your consent

I will use your confidential information necessary for payment purposes when I prepare bills to send to you or your company should I need to attempt to collect unpaid amounts due. I may disclose such information for payment purposes when bills or claims for payment are mailed, faxed, or sent by computer to you or your company, or should I have to secure the services of a collection agency or attorney to help in my collection of unpaid amounts due.
Some insurance companies reserve the right to examine your file in an auditing effort to justify payment of services. In these instances, I will inform you of the insurer’s request prior to submitting your confidential information, but you should know that payment of services may require that I meet the request.

Client Initials: _____

In other limited situations, the law allows or requires me to disclose confidential information about you, potentially including your PHI, without your permission. For example, as previously disclosed to you, I do not require your consent to use and disclose your confidential information if:

- There is a reason to believe there is an occurrence of child, elder, or dependent adult abuse or neglect
- There is reason to believe that you have serious intent to harm yourself, someone else, or property by a violent act you may commit
- You introduce your emotional condition into a legal proceeding, or if I am subpoenaed to give testimony. In such cases that I am subpoenaed to give testimony, unless in a proceeding initiated by you against me, I will make every reasonable effort to maintain your privacy. Ultimately, however, I may be required to use and disclose your confidential information, including your PHI.

Further disclosures and your rights

I will not make any other uses or disclosures of your confidential information, including your PHI, unless you sign a written authorization form. You, of course, have the right to refuse to sign such forms. Likewise, if you do sign such a form, you have the right to revoke it at any time, in writing, and no further such uses or disclosures will occur. Of course, any uses or disclosures enacted in reliance upon the signed form made prior to your revocation remain protected.

You have the right to request that I communicate with you in a confidential manner, for example, such as by phoning you only on private or protected lines or communicating with you via PO box rather than home address. I will attempt to accommodate all reasonable requests and will only charge an additional fee for such in the event that I incur an additional cost.

You have the right to see, or to get photocopies of, your files. By law, there are a few limited situations in which I can refuse to permit access or copying of certain information. For the most part, however, you are able to review or have a copy of your mental-health information within 30 days of your request. You may have to pay for photocopies in advance. If I deny your request, I will send you a written notice of explanation with instruction regarding how to receive an impartial review of my denial, should one be legally required. By law, I am entitled to one 30-day extension of the time for me to provide you with access or photocopies of your confidential information; I am required to send you a written notice of such an extension.

My duties regarding this notice of privacy practices

By law, I must abide by the terms of this Notice of Privacy Practices. I reserve the right to change this notice at any time in compliance with and as allowed by law. If I change this notice, the new privacy practices will apply to your mental health information that I already have as well as to such information that I may generate in the future. If I change my privacy practices, I will immediately make available to you the new Notice of Privacy Practices.

Complaints

If you think I have not properly respected the privacy of your confidential information, you are entitled to raise your concerns with me or with the US Department of Confidential and Human Services, Office for Civil Rights at 200 Independence Avenue, S.W., Washington, D.C. 20201. I will take no retaliatory action should you file such a complaint about my privacy practices.

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Acknowledgement of receipt of Notice of Privacy Practices

By signing this form, you acknowledge that you have received my Notice of Privacy Practices. My Notice of Privacy Practices provides information about how I may use and disclose your confidential information, including protected health information. I have encouraged you to read and understand the notice in full.

_____
_____
Date Signature

_____
_____
Date Signature

I ALSO ACKNOWLEDGE AND CONSENT TO THE USE AND DISCLOSURE OF MY CONFIDENTIAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____
_____
Date Patient's Printed Name

_____
Signature

_____
_____
Date Patient's Printed Name

_____
Signature

If you are signing as a personal representative of the patient (you are a parent, legal guardian, etc.) describe your relationship to the patient and the source of your authority to sign this form:

_____
_____

Client Initials: _____

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Relationship to Patient	Authority (if separated, divorced or as a guardian, who has granted you legal right to sign minor or dependent adult into treatment?)

Client Initials: _____