

Robyn E. Brickel, M.A., LMFT, LLC

Notice of Therapist's Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions: “*PHI*” refers to information in your health record that could identify you.

“*Treatment, Payment and Health Care Operations*”

– *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.

- *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

- *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

“*Use*” applies only to activities within our office, clinic, practice group, etc. such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

“*Disclosure*” applies to activities outside of our office, clinic, practice group, etc., such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations only when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. “*Psychotherapy notes*” are notes we have made about conversations during a private, group, joint, or family counseling session, which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations of PHI or psychotherapy notes at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have previously relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If we have reason to suspect that a child is abused or neglected, we are required by law to report the matter immediately to the Virginia Department of Social Services.

Adult and Domestic Abuse: If we have reason to suspect that an adult is abused, neglected or exploited, we are required by law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.

Health Oversight: The Virginia Board of Psychology has the power, when necessary, to subpoena relevant records should we be the focus of an inquiry.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release such information without the written authorization of you or your legal representative, or a subpoena (of which you have been served, along with the proper notice required by state law). However, if you move to quash (block) the subpoena, we are required to place said records in a sealed envelope and provide them to the clerk of court of the appropriate jurisdiction so that the court can determine whether the records should be released. The 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.

From time to time, clients find themselves in judicial proceedings and as a result we receive subpoenas to produce documents and/or to appear at a deposition, a hearing or a trial. If we receive a subpoena or other process to produce your records you will receive notice of same from the party who subpoenas the records. If you or your counsel subpoena the records, that will constitute your consent to produce the records. If another person subpoenas your records and you object to the records being produced, then you must contact us immediately to tell us of your objection and you must file a motion to quash the subpoena in court to bar the production of the records. If you do not object within the time set forth in the subpoena or within 14 days of service of the subpoena, whichever is longer, then that shall constitute your consent that the records may be produced. If we find it necessary to obtain counsel to file pleadings in court or to appear in court to contest a subpoena then you will be responsible for those reasonable attorneys' fees. Finally, if we are subpoenaed to appear in court or at a deposition to testify in any legal proceeding in which you are a party about matters related to you, then you agree to pay for our time at the rate of \$300.00 per hour.

Serious Threat to Health or Safety: If we are engaged in our professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and we believe you have the intent and ability to carry out that threat immediately or imminently, we must take steps to protect third parties. These precautions may include (1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18; or (2) notifying a law enforcement officer.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

Right to Request Restrictions –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you

request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.

Right to a Paper Copy – You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will provide our patients with a notice at their next scheduled session.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may file a complaint with Robyn E. Brickel, M.A., LMFT, LLC or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Robyn E. Brickel, M.A., LMFT, HIPPA Coordinator at her office. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on April 14th, 2003

We reserve the right to change the terms of this notice and to make the new notice provisions effective

for all PHI that we maintain. We will provide you with a revised notice at the first scheduled treatment visit after any revisions occur.

Patient Consent

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

Provide information to a third party for the patient to be reimbursed.

Conduct normal healthcare operations. For example, to evaluate the quality of care you receive from us.

I have received a copy of Robyn E. Brickel, M.A., LMFT, LLC's Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review Robyn E. Brickel, M.A., LMFT, LLC's Notice of Privacy Practices prior to signing this consent. I understand that Robyn E. Brickel, M.A., LMFT, LLC has a right to change its Notice of Privacy Practices (such as: if the Privacy Officer changes or there is a change in the law). I may contact Robyn E. Brickel, M.A., LMFT, LLC at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Robyn E. Brickel, M.A., LMFT, LLC restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand Robyn E. Brickel, M.A., LMFT, LLC is not required to agree to my requested restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Robyn E. Brickel, M.A., LMFT, LLC has taken action relying on this consent.

Patient Name: _____

Patient Name: _____

Patient Name: _____

Patient Name: _____

Patient Signature: _____

Patient Signature: _____

Patient Signature: _____

Patient Signature: _____