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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY AND SIGN ON THE BACK OF THIS FORM.

PSYCHOLOGICAL INFORMATION

Both Law and the standards of our profession require that I keep appropriate treatment records. Each time you visit my office, information about you and your psychological health is collected including: reason for seeking treatment, symptoms, thoughts, behavior, history, diagnosis, treatment planning, progress notes, records you request that others forward to me, medications, legal information, and billing and insurance information. In general all communication between a patient and psychotherapist is confidential and protected by law and can only be disclosed by written authorization. By signing this form you are authorizing the following uses and disclosures of your psychological information.
The internet, e-mail and texting are not secure or confidential forms of communication. To maintain your confidentiality, I prefer that **all** communications, including schedule changes, are by telephone, Zoom meetings when scheduled, or in person. If you must use e-mail or texting, please limit this communication to only schedule changes.

USES AND DISCLOSURES

Treatment: Your health information may be use by me for evaluation, diagnosis, treatment planning, and psychological treatment such as individual therapy or family therapy.
Payment: If you decide to use your insurance to help pay for services, your health information may be used by me and/or my assistant to seek payment from your insurance company. We may call you or your insurance company to discuss insurance coverage. Usually, only identifying information, address, dates of service, diagnoses and procedures are provided. If additional information is requested by your insurance company to pay for treatment, such as a treatment authorization, this will be discussed with you first.
Scheduling appointments: I may call your home or work to schedule an appointment.
Law enforcement: To comply with mandated reporting requirements we may have to disclose to the appropriate Governmental agency or others:

1. Suspected child abuse
2. Suspected elder abuse
3. To prevent serious and immediate danger to others
4. To prevent serious and immediate danger to you
5. A court order signed by a Judge. I will consult with you and your attorney first, and may request a hearing to reverse the order. We will not release information without your authorization, when given a subpoena by an attorney.
6. Agencies which check on me to make sure I am obeying the privacy laws.

(please turn over)

Worker's Compensation: If your treatment is covered by Workman's Compensation, a report and/or monthly summaries, will be disclosed to your attorney, the attorney for your employer and the insurance company.

Collections: should it be necessary to turn your past due account to an attorney or collection agency due to non-payment, it may be necessary to disclose identifying information, dates of service, the types of service and amount due.

Disclosure of your psychological information or its use for any other purpose than those listed above requires your specific written authorization. Conversations or disclosure of information with physicians, other mental health professionals, attorneys, school personnel or others requires specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written request to revoke your authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified me of your decision.

YOUR INDIVIDUAL RIGHTS

You have the right to receive confidential communication regarding your condition and treatment, as well as treatment alternatives.

You have the right to inspect or receive a copy your record. The cost is $.25 per/page. However, if in my opinion that reading your record may be detrimental to you, a treatment summary will be provided to you or the record maybe forwarded to another qualified Mental Health professional. You may submit corrections or request that I amend your record. However, this request must be in writing.

OUR RESPONSIBILIES

We are required to maintain your privacy and confidentiality and provide you with a copy of this Notice of Privacy Practices.

When we disclose your Psychological information we will keep a list or whom we sent it to, when and what we sent. Your may see this list.

We may amend these Privacy Practices as required by Law. You may receive a copy of these revised Privacy Practices.

If you feel your privacy rights have been violated, please discuss this with us.

_____
Signature

_____
Date

_____
Relationship to Patient