HIPPA/CONFIDENTIALITY DISCLOSURE FORM

BARDENSTEIN FAMILY CENTER

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Notice of My Policies and Practices to Protect the Privacy of your Health Information

THIS NOTICE DESCRIBES HOW MENTAL HEALTH 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

I may *use* or *disclose your protected health care information (PHI)* for *treatment, payment, and health care operations* purposes without your consent under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). However, Ohio law requires that you provide informed consent regarding the purposes of the services, limits to the services due to legal requirements, relevant costs, reasonable alternatives, your right to reuse or withdraw consent, and the time frame covered by consent. I also ask for your consent to submit information for payment purposes, which may include submission of claims to third party payors, for collection purposes, including providing claims information to the Ohio Department of Insurance for Prompt Pay purposes, for other uses and disclosures as described on our Office and Financial Policies forms. 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 whenI provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another mental health professional.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I 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 mental health practices 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 practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
  - *Disclosure* applies to activities outside of our practice group, such as releasing, transferring, or providing access to information about you to other parties.
  - These policies apply to any services received within my psychology practice, including associated therapists and clerical administrative personnel.

II

Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment , and health care operations when your appropriate authorization is obtained. An *authorization* is a specialized for specifically allowing me to disclose information for purposes outside of treatment, payment and/or health care operations. I will also need to obtain an authorization before releasing your psychotherapy notes, except under certain limited circumstances. Psychotherapy *notes* are notes I have made about the conversation you have with a mental health professional 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 other 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: (1) to the extent that I have 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, in his or her professional capacity, with some limited exceptions, I, the mental health professional know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonable indicates abuse of neglect, then I am required by law to immediately report that knowledge or suspicion to the appropriate Ohio Children Services Agency or a municipal or county peace officer in the county in which the child resides or in which the abuse or neglect is occurring or has occurred.
- **Elder and Domestic Abuse:**
  If I, mental health professional, have reasonable cause to believe than an adult age sixty years of age or older, who is handicapped by the infirmities of aging or who has a physical or mental impairment which prevents the person from providing for the person's own care and protection and who resides in an independent living arrangement is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, then I am required by law to immediately report such belief to the County Department of Job and Family Services. For Domestic Abuse, the law requires that your mental health professional note the knowledge or belief of the abuse and the basis for it in the patient's or client's record.
- **Abuse Involving a Mentally Retarded/Developmentally Disabled Person:**
  If your mental health professional has reasonable cause to believe that a mentally retarded or developmentally disabled adult has suffered a: wound, injury, disability or condition of such nature as to reasonably indicate abuse or neglect of that adults, your mental health professionally must immediately make a report to a law enforcement agency or to the county board of mental retardation and developmental disability, or if the person is in a state facility, the law enforcement agency or to the department of mental retardation and developmental disability.
- **Judicial or Administrative Proceedings**:
  If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release this information without written authorization from you or your personal legally-appointed representative or a court order. 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.
- **Serious Threat to Health or Safety:**

If I, as your mental health therapist, believe that you pose a clear and substantial risk of imminent serious harm to yourself or another person, I may disclose your relevant confidential information to public authorities, the potential victim, other professionals and/or your family in order to protect against such harm. If you or a knowledgeable person communicates to me, as your mental health therapist, an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and your I believe that you have the intent and ability to carry out the threat, I may take one or more of the following actions in a timely manner: (1) take steps to hospitalize you on an emergency basis; (2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional; (3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim(s)' parent or guardian: (a) the nature of the threat; (b) your identity; and (c) the identity of the potential victim(s).

- If **Worker's Compensation:**
  If you file a worker's compensation claim, I may be required to give your mental health information to relevant parties and officials, even without your authorization.

IV
Patients' Rights and Mental Health Therapist's Duties

Patients' Rights

- **Right to Request Restrictions:**
  You have the right to request restrictions on certain uses and disclosures of protected health information about you. I am not, however, required to agree to a restriction that you request. This restriction on uses and disclosures may not include a limitation affecting our right to make a use or disclosure that is required by law or, when in good faith, to use or to disclose to avert a serious threat to health or safety of a person or the public and such use for disclosure is made to a person or persons reasonably able to prevent or lessen the threat (including the target of the threat).
- **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 locations. For example, you may not want a family member to know that you are seeing a mental health therapist. Upon your request, I will send your bills to another address. Or, you may request that I not call you at home. Upon your request, I will contact you at another phone number.
- **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 and the information has been collected for treatment purposes. There are some limited exceptions where you will not be permitted to inspect and copy records involving your PHI, but, in those circumstances, I will provide you with reasons for any denial of access and notify you of any appeal rights that you may have.
- **Right to Amend:**
  If you have the right to inspect and copy your records, you have the right to request an amendment of PHI as long as the PHI is maintained in the record. We may deny your request. On your request, I will discuss with you the details of the amendment process.
- **Right to an Accounting of Disclosures:**
  You generally have the right to receive an accounting of disclosures of PHI involving disclosure for other than treatment, payment or health care operations or pursuant to an authorization (as described in Section III of this Notice). Upon your request, I 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 the notice from us upon request, even if you have agreed to receive the notice electronically.

Access to Minor's files

- Parents are entitled to their minor children's (under 18 years of age) PHI and psychotherapy notes, unless restricted by court orders. It is my practice that, if the parents are divorced or are in the process of divorce, both parents can access PHI and notes regarding their child, but not the clinical material generated by the other parent in individual meetings, without that parent's consent. To insure that each parent in a high conflict situation is able to speak freely and confidentially, parents can sign a consent to treatment for themselves, along with their minor child, so that all parties are considered "identified patients" and entitled to confidentiality.

Therapist's Duties:

- I am 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.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I provide you with a notice of such changes, however, I am required to abide by the terms currently in effect.
- If I revise our Notice of Privacy Practices form, I will distribute to you copies of our new Notice as required by HIPAA.

V
Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision that I have made about your access to records, you may contact me at my office: 216-229-4200.

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

VI
Effective Date

This Notice went into effect on April 14, 2003, and was revised/reviewed on November 20, 2019.

BARDENSTEIN FAMILY CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE FORMS

By signing this document, I acknowledge that I have received a copy of the Notice of Privacy Practices form. I also acknowledge that I have had a chance to ask questions about it.

_____ _____ _____

Name of client (Print) Signature Date

GUARDIAN/PERSONAL REPRESENTATIVE

(Has legal authority over Health Care of client)

_____ _____ _____

Name (Print) Signature Date

_____

Provide description of legal authority. (For example: Legal Guardian; Durable Power of Attorney for Health Care; other legal authority.)

Therapist's use only below:

Date signed that acknowledgement was reviewed: _____

Or: Reason that signature was not obtained:

_____