NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW CAREFULLY

This notice informs you about the ways in which, I may collect, use, and disclose your protected health information (PHI), and your rights concerning your protected health information. Protected Health Information is information about you, including demographic information that can reasonably be used to identify you and that relates to your past present or future physical or mental health condition, the provision of the health care to you, or the payment of that care. I am required by state law RCW Chapter 70.02 and Federal Regulations Privacy Rule 45 CFR Part 160 and Subparts A and E of Part 164 to provide you with this notice about your rights and my legal duties and privacy practices with respect to your protected health information. Some of the uses and disclosures described in this notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

I will be responsible for entering information into your mental health record. Other authorized persons who may need access to your information must also abide by this notice which could include business associates (e.g. a billing service and insurance auditors) for the purpose of health care operations. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

I must follow the terms of this notice while it is in effect. However, I reserve the right to change the terms of this notice and my privacy policies at any time. Any changes will apply to the PHI I already have. In the event that I change my policies, I will promptly update this notice and provide you with copy. You may also request a copy of this notice at any time.

HOW I MAY USE OR DISCLOSE YOUR PHI WITHOUT YOUR CONSENT

I may use and disclose your PHI for different purposes. The examples below are provided to illustrate the types of uses and disclosures I may make without your specific consent or authorization and are not intended to be a complete list.

For Treatment: I may use and disclose your protected health information to assist your health care providers (doctors, mental health practitioners, pharmacies, hospitals, ambulance services and others) in your diagnosis and treatment. For example, I may disclose your PHI to providers to provide information about alternative treatments.

To Obtain Payment For Treatment: I may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, I may use your PHI to process claims or be reimbursed by another insurer that may be responsible for payment.

For Behavioral Health Care Operations: If you are enrolled through a group health plan, I may provide summaries of claims and expenses for enrollees in a group health plan to the plan sponsor, who may be an employer. I may use and disclose your PHI for operational purposes. For example, your PHI may be disclosed to quality assurance personnel and others to evaluate the performance of staff, to assess the quality of care and outcomes in your case and similar cases. I may also contact you to provide appointment reminders or to offer information about treatment alternatives or other mental health-related benefits and services that may be of interest to you. I may mail explanation of benefits forms and other mailings containing PHI to the address I have on record for the subscriber of the health plan.

OTHER PERMITTED OR REQUIRED DISCLOSURES

As Required by Law: I must disclose PHI about you when required to do so in compliance with the law. This may include health care licensure related reports, public health reports and law enforcement reports. If there is a complaint brought against me I will be required to make disclosure of your PHI to the US Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of privacy rules. I may also disclose PHI about you in certain cases in response to a subpoena, discovery request or other lawful process.

Public Health or Safety Activities: I may disclose PHI to public health agencies to avert a serious threat to public safety with some limitations when necessary to prevent a serious threat to health and safety of the public or another person.

Abuse or Neglect: I may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect. However, the information I disclose is limited to only information that is necessary to make the initial mandated report.

Criminal Activity on Business Premises / Against Staff or Myself: I may disclose your PHI to law enforcement officials if you have committed a crime on the premises or make a threat to harm me or personnel.

In the Event of a Medical Emergency: I may disclose your PHI to law enforcement, medical personnel or family members in the event of a medical emergency on the premises in order to assist you in obtaining medical care.

Workers Compensation: I may disclose protected health information to the extent necessary to comply with state law for workers compensation programs.

Health Oversight Activities: I may disclose PHI to health oversight agencies such as government agencies and organizations that provide financial assistance to the program such as third party payors

and peer review organizations performing utilization and quality control. If I disclose PHI to an oversight agency I will have an agreement in place that requires the agency to safeguard the privacy of you PHI.

Law Enforcement: I may disclose PHI under limited circumstances to the following entities: to a law enforcement official in response to a warrant or similar process, to identify or locate a suspect, or to provide information about the victim of a crime.

Research: Under certain circumstances, I may disclose PHI about you for research purposes, provided certain measures have been taken to protect your privacy.

Special Government Functions: I may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.

Health Information Not Protected: I may disclose health information about you that is not PHI; that is, information used in a way that does not personally identify you or reveal who you are.

OTHER USES OR DISCLOSURES WITH AN AUTHORIZATION

Other uses or disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under a health plan.

YOUR RIGHTS REGARDING PHI

You have certain rights regarding your PHI that we maintain about you. They are as follows:

Right to Access Your Protected Health Information: You have the right to review or obtain copies of your PHI records, with some limited exceptions: usually the records include enrollment, billing, claims payment, or case management records and do not include psychotherapy notes, to which access is prohibited by law. Your request to review and/or obtain a copy of your PHI records must be made in writing. If you request a copy of the information, I reserve the right to charge a fee for the cost of copying, mailing or other supplies associated with your request. I will inform you of the cost in advance.

Right to Amend Your Protected Health Information: If you believe PHI maintained by me is incorrect or incomplete, you may request that I amend the information. Your request must be made in writing and must include the reason you are seeking a change.

I may deny your request if, for example, you ask me to amend information that was not created by me, or if you ask to amend a record that is already accurate and complete or not part of my records. If I deny your request to amend your information, you have the right to file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information: You have the right to request that I restrict or limit how I use or disclose your PHI for treatment, payment or health care operations with exception to disclosures that I am legally required or allowed to make.

I am not required to agree to your request. If I agree, I will comply with your request unless the information is needed for an emergency. To request restrictions you submit your request in writing. In your request, you must tell me (1) what information you want to limit; (2) whether you want to limit how I use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

Right to an Accounting of Disclosures Made by Me: You have the right to request an accounting of disclosures I have made of your protected health information. The list will not include my disclosures related to your treatment, to payment, to health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want to receive the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, I may charge for providing the accounting but I will tell you the cost in advance.

Right to Receive Confidential Communications: You have the right to request that I use a certain method to communicate with you, such as paper or electronic communication, or that I send information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from me could endanger you. I will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. I reserve the right to deny a request if it imposes an unreasonable burden on my practice.

Right to a Copy of this Notice: You have a right at any time to request a paper copy of this Notice even if you had previously agreed to receive an electronic copy.

CONTACT INFORMATION FOR EXERCISING YOUR RIGHTS

You may exercise any of the rights described above. I act as my own Privacy Officer. If you have any questions about this Notice of Privacy Practices, please contact me at the information provided at the end of this Notice.

CHANGES TO THIS NOTICE

I reserve the right to change the terms of this Notice at any time, effective for PHI that I already have about you as well as any information that I receive in the future. I will provide you with a copy of the new Notice whenever I make a material change to the privacy practices described in this Notice.

COMPLAINTS
If you believe that your privacy rights have been violated, you may file a complaint with me and/or the Secretary of the Department of Health and Human Services. All complaints to me must be made in writing and sent to the address listed at the end of this Notice. I support your right to protect the privacy of your PHI. I will not take any retaliatory action against you or penalize you for filing a complaint.

EFFECTIVE DATE OF THIS NOTICE
This Notice went into effect on April 14, 2003.

CONTACT INFORMATION
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ATTESTATION

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I have been provided the Notice of Privacy Practices either by reading at the commencement of counseling, downloading it from EnvisionIntegrativeTherapies.com or a printed copy and have had a chance to ask questions about how my personal health information will be used. By signing this document, I am attesting that I have received, read, and understand the privacy practices.

Signature of Client: _____ Date: _____ (11.2015)

Note: A photocopy or facsimile of the above signatures shall be considered in lieu of the original