

HIPPA PRIVACY NOTICE

Desired Outcomes Counseling (DOC)

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

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of your individual identifiable health information; this is, *Protected Health Information (PHI)*, as that term is defined in the HIPAA under *Information*.

THE EFFECTIVE DATE OF THIS NOTICE IS APRIL 14, 2003. DOC is required to follow the terms of this Notice until it is replaced. DOC may make changes to the terms of this Notice at any time. **Upon your request**, we will provide you with a copy of the current Notice. DOC reserves the right to make the changes apply to your *Information* maintained in my files before and after the effective date of the new Notice. The following is a general description of how Federal and State law permits me to use and disclose your *Information*.

Purposes for which DOC May Use or Disclose Your Mental Health Information with your Consent
DOC may request your consent for the use and/or disclosure of your *Information* for *treatment, payment or health care operations* as described below:

- *Treatment*. DOC will use and disclose your *Information* to provide, coordinate, or manage your mental health care and any related services. DOC may disclose your *Information* to physicians, therapists, other mental health providers, or other health care providers who are treating you or assisting in your diagnosis, treatment, or recovery.
- *Payment*. Your *Information* will be used and disclosed, as needed, to obtain payment for your mental health care services. This may include certain activities that your health insurance plan undertakes before it approves or pays for the mental health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and utilization review activities. If more than one, third party payer is responsible for payment for your health care, DOC may disclose your *Information* to more than one health plan and those health plans may share your *Information* with each other. Your *Information* may also be used and disclosed as needed to obtain payment for mental health care services rendered to you by other providers.
- *Mental Health Care Operations*. DOC may use or disclose, as needed, your *Information* in order to support my delivery of mental health care services. DOC may call you by name in the waiting room area. DOC may use or disclose your *Information*, as necessary, to contact you to schedule an appointment or remind you of your appointment.

DOC may share your *Information* with third party Business Associates who perform various administrative services. For example, those within DOC, or with whom DOC contracts, who perform billing services, transcription services, record retention, or other professional consultants. Whenever an arrangement between a Business Associate and me involves the use or disclosure of your *Information*, we will have a written contract that contains terms that will protect the privacy of your *Information*.

- **Health Care Services.** Your *Information* may be used and disclosed to contact you and to give you information about treatment alternatives or other health benefits and services that may be of interest to you.

Uses and Disclosures With Your Verbal Consent

Your *Information* may be disclosed to a family member, friend, or other person designated by you or as designated by the law, if you verbally agree.

Uses and Disclosures with Your Written Authorization

Except as provided below, your *Information* will not be used for any non-routine purposes unless you give your written authorization to do so. If you give written authorization to use or disclose your *Information* for a purpose that is not described in this Notice, then, with certain exception, you may revoke it in writing at any time. Your revocation will be effective for the *Information* DOC maintains, unless DOC has taken action in reliance on your authorization.

Uses and Disclosures Without Your Consent

- As required by law;
- To comply with legal proceedings, such as a court or administrative order or subpoena;
- To law enforcement officials for limited law enforcement purposes;
- To a coroner, medical examiner, or funeral director about a deceased person;
- To avert a serious threat to your health or safety or the health or safety of others;
- To a governmental agency authorized to oversee the mental health care system or government programs;
- To federal officials for lawful intelligence, counterintelligence, and other national security purposes; and
- To public mental health authorities for public health purposes.

Your Rights

You may make a written request to me to do one or more of the following concerning your *Information*:

- Put additional restrictions on use and disclosure of your *Information*.
- Communicate with you in confidence about your *Information* by a different means than DOC is currently doing.
- See and get copies of your *Information*.
- Receive a list of disclosures of your *Information* that DOC has made for certain purposes for six (6) years prior to your request (after April 14, 2003), with certain exceptions permitted by law, which includes exceptions for disclosure made directly to you or made pursuant to your authorization.

If you want to exercise any of these rights or require further information about privacy practices, please contact me at the address below. In certain instances, DOC is not required to agree to your request. DOC will give you the necessary information and forms for you to complete and return to request your *Information*. DOC is permitted, by law, to charge you a fee for copying any documents requested in accordance with your rights as listed above. (Fee \$1.00 per page.)

Complaints

If you believe that DOC violated your privacy rights, you have the right to complain to me or to the Secretary of the U.S. Department of Health and Human Services (DHHS). You may file a written complaint with me at the address below. An individual must file a complaint within 180 days of

when he/she knew or should have known that the act or omission occurred, unless the time limit is waived by the Secretary of DHHS. DOC will not retaliate against you if you choose to file a complaint.

Contact Address:

Desired Outcomes
Kimberley Pollock, LPCC, CEAP
8050 Beckett Center Dr., STE 314
West Chester, OH 45069

PRIVACY NOTICE ACKNOWLEDGEMENT

As a client of Desired Outcomes Counseling, I acknowledge that I have been given or offered the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of my individually identifiable health information, by Desired Outcomes Counseling.

Client Name or Guardian _____

Client Signature _____ Date _____

May 2005