



LIFE CHANGES COUNSELING, LLC

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 IT CAREFULLY.

Life Changes Counseling LLC is committed to protecting your health information, as required by law. Protected Health Information (PHI) includes any identifiable information that I obtain from you or others that relate to your physical or mental health, the health care you have received, or payment for health care. As required by law, this notice provides you with information about your rights and my legal duties and privacy practices. In order to provide treatment or to collect payments for services, I will ask for certain health information, and that information will be put into your record. The record usually contains your symptoms, diagnoses, and treatment information. That information, referred to as your medical record, and legally regulated as health information, may be used for a variety of purposes.

PERMITTED USES & DISCLOSURES:

The following are some examples of the possible uses and disclosures of your health information:

For Treatment: I may use or share your health information when I 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.

To Obtain Payment: I may use and disclose your health information in order to bill and collect payments. For example, I may disclose health information to your health insurer in order to obtain reimbursement for health care services and determine your insurance benefits.

For Health Care Operations: I may use and disclose your information for activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, and business-related matters such as audits and administrative services.

Information Purposes: Unless you provide me with alternative instructions, I may send appointment reminders and other materials to you via contact information you have provided.

SPECIAL CIRCUMSTANCES THAT PERMIT OR REQUIRE THERAPISTS TO DISCLOSE HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION:

When Required By Law: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records

thereof, such information is privileged under state law, and I will not release information without your written consent or a court order.

Child Abuse: If I have reason to believe that a child has been subjected to abuse or neglect, I must report this belief to the appropriate authorities.

Adult and Domestic Abuse & Neglect: I may disclose protected health information to appropriate authorities if I reasonably believe that you may be a possible victim of abuse, neglect, domestic violence, self-neglect, or exploitation.

Serious Threat to Health or Safety: If you communicate to me a serious and specific threat of imminent harm to your health and safety or to the health and safety of another individual or to the public; or if I believe that there is a clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

Health Oversight Activities: If I receive a subpoena from the Maryland Board of SOCIAL WORKERS because they are investigating my practice, I must disclose any health information requested by the board.

Judicial and Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order.

REGARDING PSYCHOTHERAPY NOTES:

“Psychotherapy Notes” are notes I have made about our work in our sessions, which I have kept separate from the rest of your medical record. This is highly sensitive information and is only for my use. These records are not released to the insurance company or the managed care company. HIPAA ensures that psychotherapy notes are given a greater degree of protection than other personal health information.

PATIENT RIGHTS:

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction that 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 protected health information by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address).

Right to Inspect and Copy: You have the right to see your health information or to obtain copies upon your written request. I may deny your access to Psychotherapy Notes if I believe the disclosure will be injurious to your health or

...therapy notes if I believe the disclosure will be injurious to your health or to our work. However, I will provide a summary of the notes. If you want copies of your health information, there will be a \$35 fee for copying, postage, and preparing a summary of your notes or other records.

Right to Amend: If you believe the information in your record is incorrect or missing important information, you have the right to request in writing an amendment for as long as your health information is in my records. I may deny your request (for example, if I believe the information is correct and complete).

Right to an Accounting: You have the right to request a list of the disclosures made. Exceptions are health information that has been used for treatment, payment, and health care operations. Other exceptions include information that has been disclosed to you or with your written authorization.

Right to a Paper Copy: You have the right to receive a paper copy of this notice from me upon request.

THERAPIST DUTIES:

I am required by law to maintain the privacy of health information and to provide you with a notice of my legal duties and privacy practices with respect to personal information you give me.

I reserve the right to change my privacy practices and the terms of this notice at any time. I will make a good faith effort to provide you with a revised statement in a timely manner.

QUESTIONS & COMPLAINTS:

If you have any questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, please contact me.

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to my office address.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

**MARYLAND HIPAA NOTICE ACKNOWLEDGMENT
& CONSENT TO BE TREATED**

I ACKNOWLEDGE THAT I HAVE RECEIVED AND UNDERSTAND THE PRIVACY PRACTICES NOTICE, WHICH DESCRIBES Life Changes Counseling LLC POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF MY HEALTH INFORMATION, AND I AGREE TO BE TREATED.

NAME OF PATIENT (PLEASE PRINT)

SIGNATURE OF PATIENT

DATE

