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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal law that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronic, on paper, or orally, are kept properly confidential. HIPAA gives you, the client, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

Each time you meet with your therapist, a record is made which may contain your symptoms, diagnoses, treatment, a plan for future treatment, and billing-related information. Usually, less information is recorded if you are not using insurance to pay for treatment. This notice applies to all of the records of your care generated by Valeriya Cotten, MA, LPC.

What is "Medical Information"?

The term “medical information” is synonymous with the terms “Patient Health Information” and “protected health information” (PHI) for purposes of this Notice. I need to use your PHI information in my office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you.

My commitment to your privacy:

I am required by law to maintain the privacy of your PHI, and my practice is dedicated to safeguarding the confidentiality of your personal health information as part of providing professional care. As the Privacy Officer of this practice, I have a duty to develop, implement and adopt clear privacy policies and procedures for my practice and I have done so. I want you to know how your PHI is going to be used in this office for purposes of treatment, payment, and health care operations

(TPO) and your rights concerning those records. **Before we begin any health care operations I must require you to read and sign this form stating that you understand and agree with how your records will be used.** If you would like to have a more detailed account of my policies and procedures concerning the privacy of your PHI I encourage you to read the the longer version of NPP that is available to you at the front desk before signing this consent.

Disclosing your protected health information with your consent:

I will use the information I collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice I will ask you to sign the **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, I cannot treat you. If I want to use or send, share, or release your information for other purposes, I will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent:

There are some times when the laws require me to use or share your information. For example:

1. When there is a serious threat to your health and safety or to the public. I will only share information

with persons who are able to help prevent or reduce the threat.

2. When I am required to do so by lawsuits and other legal or court proceedings.

3. If a law enforcement official requires me to do so.

4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of the notice of privacy practices.

Your rights regarding your health information:

1. You can ask me to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home, and not at work, to schedule or cancel an appointment. I will try my best to do as you ask.

2. You can ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information I have about you, such as your medical records. You can get a copy of these records, but I may charge you for it.

4. If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation. You have to make this request in writing and send it to the privacy officer. You must also tell me the reasons you want to make the changes.

5. You have the right to a copy of this notice. If I change this notice, I will post the new version in the waiting area.

6. You have the right to refuse to sign this consent for the purpose of treatment, payment and health care operations. If so the therapist has the right to refuse to give care.

7. You have the right to file a complaint if you believe your privacy rights have been violated. Because I am the Contact Person of this practice, you may complain to me and to the Secretary of the U.S. Department of Health and Human Services. I will not retaliate against you in any way for filing a complaint with me or with the Secretary.

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Consent to Use and Disclose Your Health Information

By signing this form, you are agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard my notice of privacy practices, which explains in more detail what your rights are and how I can use and share your information.

After you have signed this consent, you have the right to revoke it by writing to me. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and I cannot change that.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

_____
Description of personal representative's authority

_____
Signature of authorized representative of this office or practice

The effective date of this NPP is June 10, 2013

Copy given to the client/parent/personal representative____

For Office Use Only

I attempted to obtain written acknowledgment of receipt of my Notice of Privacy Practices, but acknowledgment could not be obtained because:
Individual refused to sign.
Communications barriers prohibited obtaining the acknowledgment.
An emergency situation prevented me from obtaining acknowledgment.
Other (please specify)
_____
_____
_____

This form will be retained in your medical record. This form is educational only, does not constitute legal advice, and covers only federal, not state, law.

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