Notice of Privacy Practices

In accordance with the requirements set out by HIPAA

This document describes how mental health information about you may be used and disclosed and how you can access this information. Please review it carefully.

I have a duty to maintain the privacy of your mental health information and to provide you with this notice. You provide your consent to, and affirm your understanding of, the policies outlined here by signing at the bottom of this form. Please ask any questions you have to ensure that your consent is fully informed and made freely.

Once you have signed this notice, I may use or disclose your Protected Health Information for purposes of diagnosis, treatment, obtaining payment, or to conduct healthcare operations. For example, if you choose to use insurance to reimburse you for payment of your counseling services, your insurance company will require information about you regarding these services. However, under most other circumstances, the release of information about you gathered while in counseling with me requires your written consent. This includes information about you used to coordinate your care with other providers including other therapists, doctors, etc.

The following comprise other permitted and required uses and disclosures that may be made *without* your consent, authorization, or opportunity to object:

Abuse or Neglect: If I suspect abuse or neglect of a child or an elder, I am mandated by law to report it to the public authorities.

Danger: If I suspect you are in imminent danger of harming yourself, I am mandated to take action to protect you with or without your consent. If I suspect you are in imminent danger of harming others, I am mandated to notify the person or persons being threatened as well as the public authorities.

Legal Proceedings: I may be required to disclose Protected Health Information in response to a court order or subpoena or in certain other legal proceedings.

You have the following rights regarding the health information I maintain about you:

Right to Inspect and Copy: You have the right to inspect and request copies of the information that may be used to make decisions about your care. Usually this includes demographic and billing records, but does not include psychotherapy notes.

You also have the right to inspect and request copies of your complete file including all psychotherapy notes. This request must be followed by a face to face meeting to review and discuss the record together prior to any release of copies. Payment for this meeting will be same as for any psychotherapy session, however, if the person requesting is no longer a current client, insurance companies may not provide reimbursement for this meeting, as it may not meet the insurer's guidelines for what constitutes a reimbursable counseling service. It is the requestor's responsibility to pay for the session in full according to the current rate for a full session.

In order to inspect and/or receive copies of information, a request must be submitted in writing. I may charge a fee for the cost of copying, mailing or other supplies associated with your request. I must respond to your request within 15 days of receipt.

Right to Amend: If you feel that health information about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as I keep the information. Your request for an amendment must be in writing and must provide a reason supporting your request.

Right to an Accounting of Disclosures: You have a right to request an accounting of disclosures I have made of the information about you. You must submit your request in writing to the address printed at the bottom of this form. Your request must state a time period for the disclosures, which may not be longer than six years and may not include dates before July 27, 2011. For records prior to that, please contact The Women's Center of Vienna (703) 281-4928.

Right to Request Restrictions on Uses and Disclosures: You may request that disclosure of confidential information be limited. If I am unable to agree to that restriction, we can discuss other options, such as referral to another counselor.

Right to Limit Reception of Confidential Information: You may request, for example, that I only contact you at certain telephone numbers or at a certain address. You are not required to provide a reason for this request.

Right to a Paper Copy of this Notice: You have a right to be informed of other uses and disclosures of Protected Health Information and any disclosures of Psychotherapy Notes, Treatment Plans, Assessments, etc. will be made only with your written authorization. After such authorization is given, you may revoke it at any time.

This Notice may be amended as needed to comply with federal, state, and professional requirements. If you believe your privacy rights have been violated, please let me know either in writing or by talking with me. You may also file a complaint with the Secretary of the US Department of Health and Human Services.

Effective July 1, 2011

Updated August 5, 2015

I/we have read and understand the information in this notice.

Signature: ____ Date: ______________________
Signature: ____ Date: ______________________
Signature: ____ Date: ______________________
Signature: ____ Date: ______________________