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NOTICE OF PRIVACY PRACTICES

(Reviewed and updated 8/16/2022)

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

NOTICE OF PRIVACY PRACTICES

As a licensed mental health counselor, I am required by applicable federal and state law to maintain the privacy of your protected health information (PHI). I am also required to give you this Notice about my privacy practices, legal obligation, and your rights concerning your PHI. I must follow the privacy practices described in this Notice. Some of these practices may be familiar to you from other healthcare settings in which you receive treatment, as they are standard HIPAA privacy practices. However, please review this information, as it is important to our working relationship that you understand how I will protect your privacy.

USES AND DISCLOSURES OF HEALTH INFORMATION I may use and disclose your PHI for treatment, payment, and healthcare operations. • "Treatment" is when I provide your health care or manage it, for example by seeking a consultation with another health care provider. • "Payment" refers to reimbursement or an attempt to obtain authorization or reimbursement for services. By signing the Informed Consent to Treatment form, you authorize me to provide your insurance company with necessary information for you to collect reimbursement for my services as an out-of-network provider • "Health Care Operations" are activities that relate to running my practice including accreditation, certification, licensing or credentialing activities.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

By signing an Authorization to Release Information form, you allow me to use or disclose your PHI for purposes of treatment, payment, and healthcare operations. I will request that you sign an Authorization to Release Information form if I am asked to release information about you to another party. I will also request that you sign an Authorization to Release Information form if you request that I release psychotherapy notes, which are notes recorded by me for the purposes of providing the best care possible. These notes contain sensitive information, will be used only by me, and will not otherwise be used or disclosed without your written authorization. You may revoke any authorization at any time by written request. You may not, however, revoke an authorization if I have already taken action on it based on your prior consent and signature. If an authorization was obtained as a condition for acquiring or using insurance benefits, the insurance company has a legal right to receive information to contest a claim.

USES AND DISCLOSURES NOT REQUIRING YOUR CONSENT OR AUTHORIZATION I may use or disclose PHI when I am required or permitted to do so by law, or in the following situations:

• If I reasonably suspect any child, elder or vulnerable person is currently being abused, abandoned, exploited or neglected, I am required to report my suspicion and the information on which it is based to the Washington State Department of Social and Health Services. or Maine Department of Health and Human Services. • If I have reasonable cause to believe that you are a threat to your own or another person's health and safety, I am required to take necessary action in order to protect your well-being or that of another person. This action might include notifying an emergency contact person or seeking the support of a family member to help ensure that all parties stay safe. • If I am presented with a court order to testify or release records. • Your PHI may be disclosed to necessary parties involved if you file a legal or administrative claim against me. Your identifying information may be disclosed to debt collection agency personnel if you fail to pay for my professional services by our agreed upon time period. • If you file a Worker's Compensation claim, and I am being compensated for your treatment by your employer or its insurance company as a result of that claim, I must provide, upon request, legally required reports and other information related to your condition • When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Health Insurance Portability and Accountability Act (HIPAA). Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, a health oversight agency (such as DHHS), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

LIMITS TO THE THERAPY RELATIONSHIP

When we negotiate a treatment or consultation plan, we will discuss the nature and scope of our relationship. Please understand that in following the standards of my profession and the ethical guidelines of the American Counseling Association (ACA), I can only be your counselor or consultant and therefore cannot have other roles, such as friend (including "friend" on social media), or knowingly become a client of your work or services.

CLIENT RIGHTS

• Right to Inspect and Copy: You may request access to your medical and/or billing records maintained by my office in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. • Right to Request Restrictions: You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing. I am not required to agree to any such restriction you may request.

• Right to Accounting of Disclosures: Upon written request, you may obtain an accounting of certain disclosures of PHI made by me. This right applies to disclosures for purposes other than treatment, payment of health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.
• Right to Request Amendment: You have the right to request that I amend your PHI. Your request must be in writing, and it must explain why the information should be amended. I must respond to your request within ten (10) days. I may deny your request under certain circumstances.
• You have the right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation

of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.
• Right to Obtain Notice: You have the right to obtain a paper copy of this Notice at any time.

COUNSELOR DUTIES

I am required by law to maintain the privacy of your PHI and to provide this notice outlining my policy regarding the privacy of your PHI. I may on occasion change my privacy policies and will notify you in writing at your next psychotherapy appointment following that change. Unless I notify you of a change, my policies will remain as written in this document.

COMPLAINTS

I strive to abide by the rules and ethical principles of the American Counseling Association (ACA) and by those of the Washington and Maine state licensure boards. If you believe that I have violated your privacy rights or you disagree with a decision that I make regarding access to your PHI, or you have concerns about your therapy, I hope you'll address this with me so that we can more fully discuss it. You can also contact the Washington State Department of Health at (360) 236-4700 or the Maine Board of Counseling Professionals Licensure at (207) 624-8660.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of my Notice of Privacy Practices.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.