Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

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NY State License # 68-021345

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THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

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I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. I will request your permission in advance, either through your consent at the onset of our relationship (by signing a consent to release information form), or through your authorization at the time the need for disclosure arises. If you are seeking reimbursement through your insurance, your insurance may request information including diagnoses, treatment plan, and session notes and attendance. I am legally allowed to use or disclose this information if you are seeking reimbursement, and will inform you if such a request is made by your insurance company and request verbal or written consent. You may revoke your permission, in writing, at any time, by contacting me.

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II. Limits of Confidentiality

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

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There are some important exceptions to this rule of confidentiality. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together. I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

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Emergency: If you are involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

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Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by New York law to report the matter immediately to the New York State Child Protective Services.

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Serious Threat to Health or Safety: If you communicate to me a specific and immediate threat to cause serious bodily injury or death to yourself or to another identified or identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to notify a law enforcement officer, seek your hospitalization, and/or warn the potential victims(s) or parent/guardian of the potential victim(s) if under 18.

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The SAFE Act (i.e., Secure Ammunition and Firearms Enforcement Act) was enacted into law in New York on 1/15/13. Although it is essentially a gun-control law, it contains specific reporting duties for psychologists. The SAFE Act's primary purpose is to regulate access to and possession of firearms in New York. The New York Governor's Office states that one of the goals of the Act is: "keeping guns out of the hands of convicted felons and potentially dangerous mental health patients." As a psychologist, I am required to make a report to the Director of Community Services when using reasonable professional judgment, if I conclude that a person that I am treating is likely to engage in conduct that would result in serious harm to self or others.

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If you see me accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

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Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

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III. Patient's Rights and Provider's Duties:

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Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I

disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

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Right to Receive Confidential Communications by Alternative Means and at Alternative Locations — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voicemail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

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Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process.

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Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative proceeding.

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Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

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Right to a copy of this notice – You have the right to an electronic or paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. I will have copies of the current notice available on request.

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Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

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EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on September 20, 2013

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Acknowledgement of Receipt of Privacy Notice

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Under the Health Insurance Portability and Accountability Act of 1996 (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 HIPPA Notice of Privacy Practices.

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