HIPAA PRIVACY OFFICER INFORMATION

The HIPAA Privacy Officer is Stephen Lankton. The Privacy Officer: Can answer your questions about our privacy practices; Can accept any complaints you have about our practices; Can give you information on how to file a complaint. You can call the Privacy Officer at the above numbers including 602-427-5592.

OFFICE POLICY AND PROCEDURES

1. **Therapy sessions** are 55-60 minutes with a charge of $175.00 per session. Payment is due in full at the time of appointment for non-insured patients. FEES FOR A LEGAL CASE WORK ARE $300 PER HR.
   You will be informed of any and all fees, refunds, etc., for additional services prior to participating in the service.
2. **Insurance** is not accepted.
3. **Payments** for services are **Due at Time of Service** unless payment arrangements have been made in advance. We accept cash, personal checks and credit cards (Visa, MasterCard, Discover, and American Express). There will be *no* additional charge for the use of credit cards to pay co-pay charges.
4. **Scheduled appointments are commitments**. I will make every effort to be on time for my appointment(s). If I am late for my appointment, I understand that time will be lost from my session. *If I miss an appointment and do not notify my treatment provider at least 24 hours in advance, I understand I will be charged a missed appointment fee* which will be billed to me with payment expected within 15 days of the billing date. We are aware that emergencies do arise, and 24-hour notice is not always possible and in these situations, we ask that you notify us at that time.
5. **It is my obligation** under state and HIPAA laws to report, to the proper law enforcement authorities, any individual who is likely to endanger or cause harm to herself, or himself, or to others. For example, it is mandated to report child abuse, sexual abuse, domestic abuse, elderly abuse, assault, planned or actual homicide, and planned or potential suicide.
6. **All records and communications** about the patient will be treated confidentially in compliance with applicable state and federal laws. These laws, however, obligate health care professionals to report suspected abuse or neglect, domestic violence, and those who pose a danger to themselves or others. These HIPAA laws accompany this intake packet for your full disclosure.
7. **Psychological or academic testing,** if required, will be performed by professions outside this office. Arrangements for payments for those services will be made with the test-provider.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the patient/client and the psychotherapist and the particular problems being addressed. There are many different methods that may be used to deal with the problems and these will be discussed in the treatment plan. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very *active effort* on your part, in order for the therapy to be most successful.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant parts of your life you may temporarily experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, research shows that psychotherapy has many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

You can expect that our first session will, in part, involve an evaluation of your needs and request. By the end of the evaluation, I will be able to offer you some thoughtful impressions of what our work will include and a treatment plan to follow. If you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. You have the right to participate in your treatment plan and review or revise it at any time. This will conclude with a written general treatment goal and plan complete with your signature of informed consent. Following that, therapy will then continue for the remainder of the session.

Therapy sometimes involves a large commitment of time, energy, and money so you should be very careful about the therapist you select. If you have questions about my credentials and procedures we should discuss them whenever they arise. You may withdraw consent at any time simply by informing me.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION. The following are examples of the types of uses and disclosures of your protected health care information that the provider is permitted to make and restricted from making. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures.

Treatment: *With your written consent only*, we will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, your protected health information may be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, in activities related to obtaining payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to your health insurance company to obtain approval for the hospital admission.

Business Associates: We may share your protected health information with our third party "business associates" that perform various activities (e.g., billing, transcription services). Whenever an arrangement between us and a business associate involves the use or disclosure of your protected health information we will have a written contract from them that contains terms that *will* protect the privacy of your protected health information in accordance with HIPAA rules and regulations.

Marketing to you: We may use or disclose certain health information in the course of providing *you* with information about treatment alternatives, health-related services. For example, with your consent we may mail a brochure about marital enrichment weekend workshops. You may contact us and request that these materials not be sent to you.

Written Authorization: Other uses and disclosures of your protected health information will be made *only with your written authorization*, unless otherwise permitted or required by Law as described below. You may revoke this authorization at any time in writing.

You May Obtain Your Records: The records kept by this office are available to you. It is unlikely that a client would desire to obtain their file. However, the method for obtaining your file is to submit any type of written request with your name, address, and signature. Note: Audio recordings are not retained and cannot be released due to software limitation.

2. OTHER RIGHTS YOU HAVE:

Inspect and copy your protected health information. However, we may refuse to provide access to certain psychotherapy notes or information for a civil or criminal proceeding.

Request a restriction of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for treatment, payment or healthcare operations. You may also request that information not be disclosed to family members or friends whom *you may have involved* in your therapy. Your request should state the specific restriction requested and to whom you want the restriction to apply. We may not be required to agree to a restriction that you may request, but if we are required to agree, then we must act accordingly.

Request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests authorized by you. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

Ask your provider to amend your protected health information. You may request an amendment of protected health information about you. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and your medical record will note the disputed information.

Receive an accounting of certain disclosures we may have made. This right applies to disclosures for purposes other than treatment, payment or healthcare operations, if any exist. It excludes disclosures we may have made to you, to permitted family members or friends you involved in your care, or for routine notification purposes.

Obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice electronically, you may receive additional copies of this notice.

Opportunity to Object: You have the opportunity to object or discontinue any previously authorized release of information. If you are not present or able to object, then your provider may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Healthcare: Without your consent, we may *not* disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to your health care or to that person's involvement in your health care.

Emergencies: In an emergency treatment situation, your provider shall try to provide you a Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

Communication Barriers: We may use and disclose minimal and necessary portion of your protected health information if your provider attempts to obtain acknowledgement from you of the Notice of Privacy Practices but is unable to do so due to substantial emergency or life-threatening circumstances and the provider determines, using professional judgment, that you would agree.

Situations Without Opportunity to Object: We *may be required* use or disclose your protected health information in the following situations *without your authorization or opportunity to object*:

Child Abuse, Neglect, Domestic Violence: to an appropriate authority to report child abuse or neglect if we believe or suspect that you may have been a victim or perpetrator of abuse, neglect, or domestic violence.

Law Enforcement: for law enforcement purposes, such as pertaining to victims of a crime or to prevent a crime.

As Required By Law: In general, we may be required to use or disclose your protected health information as required by a State or Federal law and limited to the relevant requirements of the law.

Legal Proceedings: in the course of legal proceedings but only if records are appropriately ordered by due process by the courts.

AZ Licensing Board Compliance: to the AZ Department of Behavior Health Examiners to investigate compliance by *this office* with their regulations.

Public Health: for public health purposes to a public health authority or to a person who is at risk of contracting or spreading disease.

Health Oversight: to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections of this office.

Food and Drug Administration: as required by the Food and Drug Administration to track product safety.

Coroner or Funeral Director and Organ Donation: for the coroner, medical examiner, or funeral director to perform duties authorized by law and for organ donation purposes if appropriate.

Soldiers, Inmates, and National Security: Preserving national security may also necessitate sharing protected health information to military supervisors of Armed Forces personnel or to custodians of inmates, as necessary.

Workers' Compensation: to comply with workers' compensation laws.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please sign and print your name and date on this acknowledgement form.

___YES, I have *read* and *taken a copy of* the Office Policies and Procedures & Notice of Privacy Practices (HIPAA) [a copy of this page and the previous 3 pages – a total of 4 pages] forms for my records.

Signature: _____Date: _____

Printed name: _____

END of Notice of Privacy Practices