Notice of HIPAA Policy and Practices and Disclosure Authorization

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.

Protected Health Information (PHI)

I, Heidi Elliot, as a Resident in Counseling, must maintain patient confidentiality as required by applicable federal, state and local laws. I am also required to establish a consistent process when there is a request for patient information from law enforcement authorities. When using, disclosing, or requesting protected health information (PHI), every reasonable effort shall be utilized to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. I am committed to ensuring the privacy and security of PHI. I will take steps to ensure that the appropriate actions are taken to properly identify and secure all individuals' PHI.

The following individually identifiable health information will be designated as PHI within my practice to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996: A. Information that relates to the past, present, or future physical or mental health conditions of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; specifically including such information in verbal, written, or electronic form. B. Names. C. Address information. D. Telephone numbers. E. Fax numbers. F. Social Security numbers. G. Medical record numbers. H. Health plan beneficiary numbers. I. Full face photographic images and any comparable images. J. Any other identifying number, characteristic, or code used to identify an individual.

When you visit a healthcare provider, you give information about your physical and mental health. The law identifies this information as PHI. This information goes into your medical or health care record or file. With your written consent, the healthcare provider can use your PHI to provide treatment, process for payment, and administer healthcare operations (TPO). Primary uses and disclosures of PHI include:

A. Treatment: Once you give consent and your treatment begins, the information you give about yourself may be used or disclosed to other health care professionals. Example: contact with past counselors, current or past physicians, or other treatment facilities, with written consent from the client.
B. Payment: The information you give about yourself may be used to seek payment from your health plan or from other sources of coverage. Example: your health insurance company may request and receive information on dates of service, the services provided, and the diagnosis and symptoms of the mental health condition being treated.
C. Operations: I can use and share your health information to run my practice, improve your care, and contact you when necessary. Example: I use health information about you to manage your treatment and services.

OTHER DISCLOSURES

The following are descriptions of some other possible ways in which I may be required or permitted by law to use or disclose your PHI. Law enforcement authorities are not covered entities for the purposes of HIPAA compliance. Therefore, I shall abide by use and disclosure restrictions as provided by law and regulation.

Mandatory Disclosure Laws

A. I shall disclose PHI to law enforcement personnel and designated protected service personnel pursuant to the mandatory disclosure laws of the Commonwealth of Virginia related to victims of child or adult abuse, neglect, or domestic violence.
B. I am required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Regulations.
C. I shall disclose PHI to law enforcement personnel or medical, hospital, or psychiatric hospitalization services in the event of a current or recent (recent defined as within 2 weeks) suicide attempt.

Court Order and Warrants

I may disclose PHI to law enforcement in compliance with and limited by relevant requirements (the information sought is relevant and material to a legitimate law enforcement inquiry, and the request is specific and limited in scope to the extent reasonably practicable in the light of the purpose for which the information is sought and de-identified PHI information could not be reasonably used) of a:

1. Signed Court Order
2. Signed Court-Ordered Warrant

3. Signed Subpoena
4. Summons issued by Judicial Officer
5. Crime occurs on the premises
6. Threat to health and safety: I may disclose PHI in conformance with ethical standards, in good faith, and in compliance with applicable law, to avert serious threat to health and safety of the person, counselor, teacher, family member, or to the public, as is necessary for law enforcement authority to identify or apprehend an individual: 6a) Because of a statement of admission of violent crime that may have caused serious physical harm to a victim. 6b) Because the individual appears to be an escapee from a correctional institution or lawful custody. 6c) For purposes of national security and lawful intelligence of the National Security Act. 6d) As required by protective services for the President and others under Secret Service Protection.

Distance Counseling

Distance counseling is defined as a delivery method that utilizes various forms of electronic technology. This may include, but is not limited to, telephone (wireless, voice over IP, and land line), secured e-mail and secured virtual video services. Attempts are made to ensure that all distance counseling policies and procedures are updated to reflect industry policy standards.

There are risks and consequences of distance counseling, including without limitation the possibility, despite reasonable efforts, that the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings can more easily occur. Although my therapist has taken reasonable and appropriate efforts to eliminate any confidentiality risks associated with its distance counseling services, the results of these efforts are only as secure as the device used by a client to receive distance counseling services.

Distance counseling services may not yield the same results nor be as complete as face-to-face services. If I believe that a client would be better served by another form of therapy (e.g., face-to-face services), I may refer such client to a third party.

Medical Examiner or Funeral Director

I can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Respond to organ and tissue donation requests

I can share health information about you with organ procurement organizations.

Workers' Compensation

I can share health information for purposes of processing workers' compensation claims.

Lawsuits

I can share health information about you in response to a court or administrative order, or in response to a subpoena in civil legal actions.

Authorization Required

In the following cases, I will not share your PHI unless you give us written permission: marketing purposes, sale of your information, most sharing of psychotherapy notes.

Designated Authority

In the event of a concern over improper disclosure or you would like more information about the policies in this notice, please contact myself directly at 703-665-9638 or heidielliotcounseling@gmail.com or reach out to my supervisor Dr. Tracy Bushkoff at 703-243-3432 or tgbushkoff@comcast.net.

Duties of Your Therapist

I am required by law to maintain the privacy of your PHI and to provide you with this notice of privacy practices. I am required to abide by the privacy policies and practices that are outlined in this notice. Similarly, any business associates who have contact with your PHI (such as a third party billing company) are obligated to respect your confidentiality and privacy in accordance with this notice. For security, your files are maintained and protected in a locked cabinet when not in use. As permitted by law, I reserve the right to amend or modify privacy policies and practices and the changes will apply to all information I have about you. These changes may be required by changes in federal and state laws and regulations. Any updated notice will be available, upon request, and on my website.

Your Rights

You have certain rights under the federal privacy standards. These include:

Right to Request a Restriction: You have a right to request a restriction on the PHI we use or disclose about you for payment or healthcare operations. I am not required to agree to any restriction that you may request. If I do agree to the restriction, I will comply with the restriction unless the information is needed to provide emergency treatment to you and as long as it allows us to comply with the law. You may request a restriction by writing. In your request tell me: 1) the information you want to limit and 2) how you want to limit our use and /or disclosure of the information.

Right to Request Confidential Communications by Alternative Means: If you believe that a disclosure of all or part of your PHI may endanger you, you may request that I communicate with you regarding your information in an alternative manner or an alternative location. For example, you can request that I only contact you at work.

Right to Inspect and Copy: As permitted by federal regulation, I require that requests to inspect, copy, or release PHI be submitted in writing. You may obtain a form to request access to your records by contacting me at 703-665-9638. If you request a copy of the information, I will charge a fee for the costs of copying, mailing, or other cost associated with your request. Please note that the law does not guarantee you the right of access to, or possession of a mental health therapist's personal or psychotherapy notes. I may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, the denial will not be reviewable. If this event occurs, I will inform you in the denial that the decision is not reviewable.

Right to Amend: If you believe that your PHI is incorrect or incomplete, you may request in writing that your information be amended. Your written request should include the reason the amendment is necessary. In certain cases, I may deny your request for the amendment. If denied, you have the right to file a statement of disagreement with me. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

Right of an Accounting: You have the right to receive an accounting of most disclosures of your PHI for reasons other than payment, treatment, or healthcare operations. This accounting will not include disclosures for which you provided an authorization. An accounting will include the date(s) of the disclosure. I am permitted to charge you for the cost of producing the list.

Rights for Confidentiality in Substance Abuse Treatment: You may have additional rights of confidentiality under 42 CFR Part 2.

Right to Receive a Printed Copy of the Notice: You have a right to receive a printed copy of this notice.

Right to File a Complaint If You Feel Your Rights Are Violated. You can complain if you feel I have violated your rights by contacting me or my supervisor listed above. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. I will not retaliate against you for filing a complaint.

Right to Choose Someone to Act For You. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. I will make sure the person has this authority and can act for you before I take any action.

CONFIDENTIAL COMMUNICATIONS CONSENT a copy of this signed consent will be given to you. Please read the following information concerning written, verbal, and electronic forms of communication. Indicate that you have read and understand the information and which forms of communication you authorize by checking or initialing next to the statements below. I will not communicate any Protected Health Information (PHI) verbally, electronically, or written unless authorized by you or permitted by law.

If you choose, I will send/receive text messages and emails about appointment times, rescheduling, cancellations, and/or other practical matters such as directions, forms, invoices, etc. I will not discuss clinical issues through text message or through email. Should you choose to disclose confidential clinical information to me in text message or email, please be aware that my response in these forms will be limited and is not recommended.

May I contact you by:

□ Mail (My logo/information may be visibly displayed on mail)

□ Cell phone (Note: cell phones are not necessarily a secure form of communication)

□ May I leave voice messages containing information regarding your treatment?

□ May I send text messages containing information regarding your treatment?

□ Home phone

□ May I leave a message containing information regarding your treatment?

□ Email (Note: email is not necessarily a secure form of communication)

Any restrictions for content of messages? (if none please indicate "none")

_____ I authorize my therapist to collect payment through an electronic payment processing portal.

You may revoke the foregoing authorizations at any time by providing a written revocation notice to me. The revocation is not effective if (i) I have taken action in reliance on the authorization or (ii) the authorization was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy or the policy itself.

The above authorizations shall automatically expire if and when you notify me of your intention to stop using my services.

I may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign the above authorizations. There is the potential for information disclosed pursuant to the authorization to be subject to re-disclosure by the recipient and no longer be protected by HIPAA privacy regulations.

FEES FOR OPINIONS OR SUMMARIES

Pursuant to federal regulations, I may charge a reasonable fee for preparing a summary of PHI. Additionally, I may charge a reasonable fee for preparing a written professional opinion and for appearing in court hearings or trials. A schedule of our fees for such services is below. These rates may be modified slightly from time to time, and you will be notified of such modified rates prior to performing such services for you.

SCHEDULE OF OPINION/LEGAL RATES

Except for situations where other arrangements have been previously arranged (e.g. substance abuse cases), current prices for professional opinion services are:
(1) $5.00 per minute for drafting professional opinions and/or letters for court, school or other use,
(2) $5.00 per minute to speak with any attorney or other legal professional that we are authorized to speak to regarding your case, and
(3) $300.00 fee plus $5.00 per minute to appear at court, including driving time and time waiting for the case to be called.
The $300 fee will be collected before the professional opinion is given, verbally or in written form.

By signing, you acknowledge that you have read and understood the Notice of HIPAA Policy and Practices and have authorized Heidi Elliot to disclose PHI as you have indicated with initials above.

Please sign below and return this form.

Client's Name _____ Date _____

Name of Parent 1/Guardian (if under 18) _____
By listing the child's parents or Guardian you have given permission to see your child for therapy.

Name of Parent 2/Guardian (if under 18) _____
By listing the child's parents or Guardian you have given permission to see your child for therapy.