FAIRVIEW COUNSELING
OF CHESTER COUNTY

Notice of Privacy Practices

This notice describes how psychological information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures for Treatment, Payment and Health Care Operations:

I may use or disclose your personal health information (PHI) for treatment, payment and healthcare operations purposes with your consent. To help clarify these terms, here are some definitions:

"PHI" refers to the information in your health record that could identify you.

I may use or disclose your PHI for three purposes: treatment, obtaining payment, and what are called health care operations.

"Treatment" is when I provide, coordinate or manage your health care and other services related to your health care. As an example of treatment would be when I consult with another health care provider, such as your primary care physician, psychiatrist or another therapist.

"Payment" is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care, to determine eligibility for coverage, or when identifying the service, you have received from me when you use a credit card as a method of payment.

"Health Care Operations" are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative duties, case management and care coordination, and my consultation with a supervisor or other professionals to better assist you.

"Use" applies only to activities within my office and practice, such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.

"Disclosure" applies to activities outside my office and practice such as releasing, transferring or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization:

I may use or disclose PHI for purposes outside of treatment, payment, health care operations when your authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations. I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "psychotherapy notes" are notes that I have made about our

conversations during a private, group, joint or family therapy session, which I have kept separate from the rest of your record. When I use your PHI or disclose it to others, I share only the minimum amount of information necessary for those other people to do their jobs.

To individuals involved in your care- when appropriate, your health information may be disclosed to a family member assisting you in receiving or obtaining payment for health care services. I will disclose your health information to these individuals only if you give written permission.

Appointments, Information or Services- I may contact you regarding appointments or other health related services that may be of interest to you. I may also use or disclose your information for judicial or administrative proceedings, or similar purposes.

Uses and Disclosures with Neither Consent nor Authorization:

I may use or disclose PHI without your consent of authorization in the following circumstances:

Child Abuse or Neglect: If, in my professional capacity, I know or suspect that a child under the age of 18 years of age has suffered or faces a threat of suffering any physical or mental wound, injury or disability, I am required by law to immediately report that knowledge to the appropriate authority.

Adult and Domestic Abuse: If I have reasonable cause to believe that an incapacitated adult is being abused, neglected or exploited, I am required by law to immediately report such belief to the Adult Protective Services.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release this information without written authorization from you.

Serious Threat to Health or Safety: If I believe that you pose a clear and substantial risk or imminent serious harm to yourself or another person, I may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to me an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and I believe you have the intent and ability to carry out the threat, then I am required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency, and, if feasible to the potential victim. If a minor, all of the following information: a) the nature of a threat, b) your identity, and c) the identity of the potential victim (s).

Worker's Compensation: If you file a worker's compensation claim, I may be required to give your mental health information to relevant parties.

Patient's Rights and Therapist's Duties:

You may revoke all such authorization of PHI or psychotherapy notes at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that I have relied on the authorization or if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

Patient Rights:

Right to request restrictions: You have the right to request restrictions on certain disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right of Access to Inspect and Copy: You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/ medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. I may charge a reasonable, cost-based fee for copies.

Right to Amend: If you feel that the PHI I have about you about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with me.

Right to an Accounting of Disclosure: You have the right to request an accounting of certain of the disclosures that I make in your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12- month period.

Right to Request Restrictions: You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment or health care options. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid out of pocket. In that case, I am required to honor your request for a restriction.

Right to Request Confidential Communication: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests.

Breach Notification: If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice: You have the right to have a copy of this notice.

***Any requests of the nature described above must be in writing addressed to Fairview Counseling of Chester County.**

Therapist Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will notify you of the revised notice in person.

Complaints:

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may send a written complain to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. I promise that I will not in any way limit your care or take any actions against you if you complain.

Effective date: 02/01/2019

PATIENT ACKNOWLEDGEMENT

I have read, understood, agree and acknowledge receiving a copy of Fairview Counseling of Chester County's (HIPAA) Notice of Privacy Practices:

Client Signature: _____

Name Printed: _____

Date: _____