Notice of Privacy Policies and Practices

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

HIPAA is a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Your rights mentioned in this document are according to HIPAA law.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. Your 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. If the need for disclosure arises, I will request your permission in advance. You may revoke your permission, in writing, at any time.

II. Limits of Confidentiality

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

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. If you have any questions about your confidentiality at any time during our work together, you have the right to ask me.

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:

▹ 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.

▹ Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by Florida law to report the matter immediately to the Florida Department of Children and Families.

▹ Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Florida law to immediately make a report and provide relevant information to the Florida Department of Children and Families.

▹ Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena.

▹ Serious Threat to Health or Safety: Under Florida law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that

threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization by initiating a Baker Act where you would be taken to an inpatient psychiatric facility to be evaluated.

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.

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

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of PHI 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.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to receive communications in a particular way or at a certain place that is more private to you. For example, you may request that I contact you only at home or at work, or that I do not leave voicemail messages. To request alternative communication, you must specify your request in writing, specifying how, or where, you wish to be contacted.

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. You may incur a fee for costs of copying and/or mailing your records.

Right to a copy of Notice of Privacy Practices: You have the right to receive a paper copy of this notice.

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

IV. Communication:

E-mail: E-mail accounts may be hacked, and any company/individual on whose server you access your email has the ability to review your messages (even with personal accounts). Furthermore, anyone with access to your account or password may use your e-mail and it is impossible to ensure that I am in fact communicating with you. For these reasons, I typically do not communicate with clients via e-mail.

Text Messages: I do not send or receive texts because it is not a confidential form of communication.

Acknowledgment of Policies and Practices

I acknowledge that I have read and understand this NOTICE OF PRIVACY POLICIES AND THERAPIST'S PRACTICES to protect the privacy of my health information.

We have discussed these policies, and I understand that I may ask questions about them at any time in the future and may receive a copy of the Notice of Privacy Policies and Practices upon request.

I consent to accept these policies as a condition of receiving mental health services from Natalie R. Noel, LMHC, and Anxiety & OCD Treatment of Tampa Bay.

____________________________________ __________
Signature of Client (if 18 years or older) Date

____
Printed Name of Client

____________________________________ __________
Signature of Parent/Legal Representative (if client is a minor) Date

____
Printed Name of Parent/Legal Representative

____
Printed Name of Minor