NOTICE OF PRIVACY PRACTICES

Paul David, Ph.D., LMFT, LMHC

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

The Health Insurance Portability and Accountability Act (HIPAA) mandates the protection and confidential handling of protected healthcare information. This Notice informs you of your rights regarding your healthcare information under HIPAA. Your health information includes any information that I record or receive about your past, present, and future healthcare. HIPAA regulations require that I maintain this privacy and provide you a copy of this Notice.

RECORD KEEPING PRACTICES

Standard practice requires me to keep a record of your treatment. This includes relevant data about dates of service, payments for service, insurance billing, and relevant treatment information. This record of treatment is your *protected health care information* or *"PHI."* I may use or disclose your PHI for treatment, payment, and healthcare operation purposes.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT, & HEALTH CARE OPERATIONS

TREATMENT. I may use or disclose your PHI to coordinate or manage your treatment. An example of *treatment* would be when I consult with another healthcare provider or therapist.

PAYMENT. I will disclose your health care information if you request that I bill a third party. An example of *payment* is when I disclose your protected health information to your health insurer to obtain reimbursement or to determine eligibility or coverage.

HEALTHCARE OPERATIONS. I may disclose your PHI during activities that relate to the performance and operation of my practice. Examples of *health care operations* are quality assessment activities, case management, legal, audits, and administrative services.

USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION OR AN OPPORTUNITY TO OBJECT

REQUIRED BY LAW. I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are public health reports, law enforcements reports, abuse and neglect reports, and reports to coroners and medical examiners in connection with death. I also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

HEALTH OVERSIGHT. I may disclose your healthcare information to a health oversight agency for activities authorized by law, such as my professional licensure. Oversight agencies also include government agencies and organizations that provide financial assistance to me, such a third-party payers.

CHILD ABUSE OR NEGLECT. If I have reasonable cause to believe that a child has suffered abuse or neglect, I am required by law to report it to the proper law enforcement agency or the Washington Department of Social and Health Services.

ADULT ABUSE. If I have reasonable cause to believe that abandonment, sexual or physical abuse, financial exploitation, or neglect of a vulnerable adult has occurred, I must report the abuse to the Washington Department of Social and Health Services.

THREAT TO HEALTH OR SAFETY. In the instance when you or someone else is in imminent danger of harm I may disclose your healthcare information for the purposes of safety.

CRIMINAL ACTIVITY. I may disclose your healthcare information to law enforcement officials if you have committed a crime on my premises or against me.

BUSINESS ASSOCIATES. I may disclose your healthcare information with business associates that I contract with to administer billing and/or legal services. My contract with them requires them to safeguard the privacy of your information.

COMPULSORY PROCESS. I may be required to disclose your personal healthcare information if a court of competent jurisdiction issues an appropriate order. I will comply with this order if (a) you and I have each been notified in writing at least fourteen days in advance of a subpoena or other legal demand, (b) no protective order has been obtained, and (c) I have satisfactory assurances that you have received notice of an opportunity to have limited or quashed the discovery demand.

USES AND DISCLOSURES OF HEALTHCARE INFORMATION WITH YOUR WRITTEN AUTHORIZATION

I will make other uses and disclosures of your protected healthcare information only when your appropriate authorization is obtained. An "authorization" is written permission that permits specific disclosures. You may revoke this authorization in writing at any time, unless I have taken an action in reliance on the authorization of the use or disclosure you permitted, such as providing you with healthcare services for which I must submit subsequent claims for payment.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

1. You have the right to ***inspect and copy*** your PHI, which may be restricted in certain limited circumstances, for as long as I maintain it. I will charge you a reasonable cost-based fee for copies.

2. You have the right to ***ask that I amend*** your record if you feel that the protected health information is incorrect or incomplete. I am not required to amend it, however you have the right to file a statement of disagreement with me, to which I am allowed to prepare a rebuttal and it will all go into your record.

3. You have the right to ***request the required accounting of disclosures*** that I make regarding your PHI. This documents any non-routine disclosures made for purposes other than your treatment, as well as disclosures made pertaining to your treatment for purposes of quality of care.

4. You have the right to ***request a restriction*** or limitation on the use of your protected health information for treatment, payment, or operations of my practice. I am not required to agree to your request, and in instances where I believe it is in the best interest of quality care I will not honor your request.

5. You have the right to ***request confidential communication*** with me. An example of this might be to send your mail to another address or not call you at home. I will accommodate reasonable requests and will not ask why you are making the request.

6. You have the right to ***have a paper copy*** of this Notice.

7. If you believe I have violated your privacy rights you have the right to ***file a complaint*** in writing with me and/or the Secretary of Health and Human Services. I will not retaliate against you for filing a complaint.

THERAPIST'S DUTIES

This Notice describes your rights regarding how you may gain access to and control your protected healthcare information and how I may use and disclose it. I am required by law to abide by the terms of this *Notice of Privacy Practices* and reserve the right to change the terms of this Notice at any time. Any new *Notice of Privacy Practices* will be effective for all personal healthcare information that I maintain, whether or not you are still in treatment with me. You may request a copy of my revised *Notice of Privacy Practices* at your appointment time, or by leaving a request on my voice mail to receive a copy through the mail. My revised *Notice of Privacy Practices* will be posted in my office.

CONTACT INFORMATION

I am my own Privacy Officer. If you have any questions about this *Notice of Privacy Practices*, please contact me. My contact information is:

Paul David, Ph.D., LMFT, LMHC
103 East Holly St. – Suite 315
Bellingham, WA 98229
206-240-3162

COMPLAINTS

If you believe I have violated your privacy rights, you may file a complaint in writing to me. I will not retaliate against you for filing such a complaint. You may also file a complaint with the U.S. Secretary of Health and Human Services.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices:

_____	_____	_____	_____
Date	Client(s) Name Printed	Client(s) Signature	Therapist's Signature