# PETTIGRU COUNSELING ASSOCIATES, INC.

**Notice of Privacy Practices**

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.

**Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your personal health information. We are required also by law to do this. These laws are complicated, but we must provide you with important information. This is a shorter version of the full, legally required NPP which is available in a notebook in the waiting room for you to refer for more information.

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services or for some other business activities which are called, in the law, health care **operations.**

**Definitions:**

1. **Protected Health Information** – is individually identifiable health information which includes all information, data, documentations and material (written, oral, visual or electronic) including demographic, medical and financial information collected from an individual or that is created or received by the practice that relates to the past, present, or future physical or mental health condition 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, that identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
2. **Treatment** – Pettigru Counseling Associates, Inc. will use the client information to provide and manage the client's treatment and related services. Treatment includes the coordination of services within the practice or with a third party; consultation between the practice personnel as well as with other health care providers relating to the client; or the referral of a patient for health care from the practice to another health care provider.
3. **Payment** – Pettigru Counseling Associates, Inc. may use and disclose a client's PHI to obtain payment for treatment and services. In general, payment includes verification of eligibility and pre-certification with a health plan, submission of billing information to Medicare, or a health insurer either directly or through a third party clearinghouse for reimbursement, utilization review and collections.
4. **Operations** – Pettigru Counseling Associates, Inc. may use and disclose a client's PHI to support the business functions of the practice, which includes administrative, financial and legal activities. These uses and disclosures are necessary to run the practice, to support the essential health care functions of treatment and payment, and to ensure that our clients received quality care.

After you have read this NPP we will ask you to sign a **Consent form** to let us use and share your information. If you do not consent and sign this form**, we cannot treat you**.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an **Authorization** to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires to do so.
4. For Workers' Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

**Your rights regarding your health information**

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records but we will charge you $20.00 for copying and handling. To arrange to see your records, contact your therapist.

4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to your therapist. You must tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. Please ask for one from the receptionist. If we change this NPP we will post it in our waiting room and you can always get a copy of the NPP from the receptionist.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Practice Manager and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact your therapist.

The effective date of this notice is April 14, 2017.

# PETTIGRU COUNSELING ASSOCIATES, INC.

**Consent to use and disclose your health information**

This form is an agreement between you, _____ and Pettigru Counseling Associates, Inc. When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business functions. By signing this form you are agreeing to let us use your information here and send to others who are responsible for your treatment, payment for services or for administrative functions. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our receptionist. If you are concerned about some of your information, you have right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. When possible, we will try to comply with your wish. After you have signed this Consent form, you have the right to revoke it by writing a letter telling us you no longer consent. **If consent is revoked, treatment will be terminated.** We may already have used or shared some of your information and cannot change that. In my capacity as Personal Representative, I have been sufficiently advised and give my informed consent to participate in the psychotherapy, medical treatment, psychological assessment, psychoeducational evaluation, and/or related mental health services of the above-named client
**If you do not sign this Consent form agreeing to what is in our Notice of Privacy Practices <u>we cannot treat you.</u>**

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

Date of NPP _____ ☐ Copy given to the client/parent/personal representative

## Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please print name Signature Date

If you are a guardian signing for a minor who is the client, please print the minor's name here: _____

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

**Circle one:**

1. Individual refused to sign
2. Communication barriers prohibited obtaining the acknowledgment
3. An emergency situation prevented us from obtaining acknowledgement
4. Other (please specify)_____