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NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW PSYCHOTHERAPEUTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Uses and Disclosures for Treatment, Payment and Health Care Operations

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

a.) "PHI" refers to information in your health care record that could identify you.
b.) "Treatment, Payment and Health Care Operations"
   i.) Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another mental health clinician (with a release signed by you).
   ii.) Payment is when I obtain reimbursement for your health care.
   iii.) 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 services and case management and care coordination.
c.) "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
d.) "Disclosure" applies to activities outside of my office such as releasing, transferring or providing access to information about you to other parties.
e.) "Authorization" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

Initials:_____

2. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained. In those instances, when I am asked for information outside of treatment, payment or 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 I have made about your progress during our sessions, which have been kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that:

(a) I have relied on that authorization; or
(b) If the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

Initials:_____

3. Uses and Disclosures without Authorization

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

a. Child Abuse—If I know or have reasonable cause to suspect that a child known to me in my professional capacity has been or is in immediate danger of being the victim of neglect or abuse, then I must immediately report such knowledge or suspicion to the appropriate authorities.
b. Adult and Domestic Abuse—If I know or have reasonable cause to suspect that an incapacitated or vulnerable adult has been the victim of neglect or abuse, or that exploitation of the adult's property has occurred, then I must report such knowledge or suspicion to the appropriate authorities.

c. Health Oversight Activities—If the California Board of Behavioral Sciences is investigating me or my practice then I may be required to disclose PHI to the Board.
d. Judicial and Administrative Proceedings—If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under California law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
e. Serious Threat to Health or Safety—If you communicate to me an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and I believe you have the intent and ability to carry out such a threat, then I have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police and in order to initiate hospitalization procedures. If I believe there is an imminent risk that you will inflict serious harm to yourself, then I may disclose in order to protect you and to initiate hospitalization procedures.
f. Worker's Compensation—I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Initials:_____

4. Patient's Rights and Therapist's Duties

Patient's Rights:

a. Right to Request Restriction—You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction that you request.
b. Right to Receive Confidential Communications by Alternative Means and at Alternative Locations—You have the right to request and receive confidential communications of PHI by alternative means and at

alternative locations based on your specific written request. For example, you may not want a family member to know that you are seeing me.

c. Right to Inspect and Copy—You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
d. Right to an Accounting—You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
e. Right to a Paper Copy—You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

a. 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>
b. 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.
c. If I revise my policies and procedures, then I will inform you and provide you with written documentation during our session at that time.

Initials:_____

5. 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, then please make me aware of your concern.

You may also send a written complaint to the California Board of Behavioral Sciences. I can provide you with the appropriate address upon request.

Initials:_____

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6. **Effective Date, Restrictions and Changes to Privacy Policy**

   This notice goes into effect on January 1, 2018.

   I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised written notice during our session at that tie.

   Initials:_____

By signing this form, you are agreeing to the following:

I have reviewed the information in the Informed Consent for Treatment Agreement for Adults. I have discussed this Agreement form and the contents with Nancy Vierra, MFT, and I have had my questions answered by her to my satisfaction. I fully understand this Informed Consent to Treatment Agreement for Adults. I accept, understand, and agree to abide by the contents and terms of this agreement, and further, I consent to participate in evaluation and treatment with Nancy Vierra, MFT.

Client Name:_____
(please print)

Signature:_____Date:_____

If you are a minor:

Name of Parent or Legal Guardian or Custodial Parent:

_____
(please print)

Signature of Parent/Legal Guardian/Custodial Parent:_

Signature:_____Date:_____