NOTICE OF PRIVACY PRACTICES
For
Reflections Counseling

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

This notice will inform you of your rights regarding your health information. Your health information includes notes that are created by your therapist as a result of your sessions, insurance information for the purposes of payment, and any information received about you related to your past, present, and future health. Federal regulations require that we maintain this privacy and provide you a copy of this Notice.

RECORD KEEPING PRACTICES

Standard practice requires us to keep a record of your treatment. This includes a general description of your emotional and psychological functioning, a diagnosis for insurance billing purposes, goals of treatment, symptoms, medications, your progress, and homework assignments if given. This record of treatment is your *protected health care information* or *"PHI"*. Your PHI is used for treatment, payment, and health care operation purposes.

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

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

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

HEALTHCARE OPERATIONS. Your PHI may be disclosed during activities that relate to the performance and operation of our 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. Your therapist 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. Disclosures are also made to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

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

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

ADULT ABUSE. If we have reasonable cause to believe that abandonment, sexual or physical abuse, financial exploitation, or neglect of a vulnerable adult has occurred, we 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 we may disclose your healthcare information for the purposes of safety.

CRIMINAL ACTIVITY. We may disclose your healthcare information to law enforcement officials if you have committed a crime on our premises or against one of our therapists.

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

COMPULSORY PROCESS. We will disclose your personal healthcare information if a court of competent jurisdiction issues an appropriate order. We will disclose your healthcare information if you and your therapist have each been notified in writing at least fourteen days in advance of a subpoena or other legal demand, and no protective order has been obtained, and we 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

We 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 we 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

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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 it is maintained. We may charge you a reasonable cost-based fee for copies.

2. You have the right to ***ask to amend*** your record if you feel that the protected health information is incorrect or incomplete. Your therapist is not required to amend it, however you have the right to file a statement of disagreement, to which your therapist is 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 are made 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. Your therapist is not required to agree to your request, and in instances where your therapist believes it is in the best interest of quality care your request will not be honored.

5. You have the right to ***request confidential communication*** with your therapist. An example of this might be to send your mail to another address or not call you at home. Your therapist 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 your privacy rights have been violated you have the right to ***file a complaint*** in writing with your therapist and/or the Secretary of Health and Human Services. You will not be retaliated against 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 it may be used and disclosed. Your therapist is 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 maintained, whether or not you are still in treatment at Reflections Counseling. You may request a copy of the revised *Notice of Privacy Practices* at your appointment time, or by leaving a request by voicemail to receive a copy through the mail. The revised *Notice of Privacy Practices* will be posted in my office.

CONTACT INFORMATION

We are our own Privacy Officer. If you have any questions about this *Notice of Privacy Practices*, please contact your therapist. Contact information:

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425-209-8216

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint in writing to your therapist. You will not be retaliated against for filing 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