Michelle Klein Counseling
3943 S. Atherton St
State College, PA. 16801-8308

HIPPA NOTICE OF PRIVACY PRACTICES STATEMENT

PROTECTED HEALTH INFORMATION

Information about your health is private. By law I, Michelle M. Klein, LPC am required to protect your Protected Health Information (PHI) and must follow legal regulations with respect to how I use your PHI, disclosing your PHI to others, your privacy rights, our privacy duties, and contacts for more information.

USING OR DISCLOSING YOUR PHI:

FOR TREATMENT

During your treatment, I may need to communicate with your other providers. In these instances, I would get consent for release/receive of information from you. You may revoke this at any time.

FOR PAYMENT

To be paid by your insurer, some of your PHI may be used to file the claim. This may include a description of your health problem, the treatment we provided and your membership number in the insurance health plan. Your insurer may also ask to review your medical record to determine whether your care was necessary. Also, I may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

SPECIAL USES

Your relationship to me as a patient might require using or disclosing your PHI to remind you of an appointment for treatment or tell you about treatment alternatives and options. I may also need to use and disclose your PHI in an emergency when you are not able to express yourself.

OTHER INSTANCES I MAY USE OR DISCLOSE YOUR PHI

*When required by law, for example when court ordered.
*To report neglect, abuse, or domestic violence.
*To government regulators or agents to determine compliance with applicable rules and regulations.
*In judicial or administrative proceedings (e.g. response to a valid subpoena).
*In accordance with the legal requirements of a workers' compensation program.
*If I reasonably believe that use or disclosure will avert a threat to public safety including an imminent crime to against another person or a threat to yourself.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM

*You have the right to ask me to communicate with you in a way or at a certain place that is more private for you.
*You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members.
*You have a right to ask or see a copy of your PHI. This request must be in writing and you may need to pay for the cost of copying and mailing. I may refuse to release certain information under law if I feel it will harm you or interfere with treatment, but must explain to you my reasons.
*If you believe the information in your records is incorrect or missing something important you can ask me to make additions to correct it. You must make this request in writing and tell us the reasons you want the change.
*You have a right to know who I have disclosed your PHI to except in the instance that the law does not allow it, for example with mandated reporting of suspected abuse.

IF YOU HAVE A COMPLAINT

If you think your rights are being denied or your health information is not being protected, you have the right to file a complaint with your provider, health insurer, or the U.S. Department of Health and Human Services.

CHANGES TO HIPPA DISCLOSURE

Federal health information rules require notice of my privacy policy. This document serves as this notice. I reserve the right to change the privacy policy when permitted or required by law. In this instance, I will provide you with the amended policy at your next session.

Michelle Klein Counseling
3943 S. Atherton St
State College, PA. 16801-8308

Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____ and Michelle M. Klein, LPC. When I use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

_____.

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls "protected health information" (PHI) about you. I need this information in my office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others (insurance/third party payer) to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you.

By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard my notice of privacy practices, which explains in more detail what your rights are and how I can use and share your PHI.

If you do not sign this form agreeing to our privacy practices, I cannot treat you. In the future, I may change how I use and share your information (following state and federal law), and so I may change my notice of privacy practices. If I do change it, you may request a copy.

If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, I promise to do what you asked.

After you have signed this consent, you have the right to revoke it. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and I cannot change that. I have been offered a copy of the HIPPA practices. I accepted / declined.

_____ _____
Signature of client (if over 14) Date

_____ _____
Signature of partner #2 (if applicable) Date

_____ _____
Client's parent or guardian (if under 18) Date

_____ _____
Client's parent or guardian #2 Date

_____ _____
Therapist Signature Date