ENSŌMentalHealth

ensomh.com

717 5th Street
Spearfish, SD 57783
605.519.5850

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

As part of providing professional mental health care to you, we will do all we can to maintain the privacy of what is called your **protected health information (PHI)**. We are also required by Lawton keep your PHI private. These laws are complex, and we must give you this important information. This page is a brief description of what we do to maintain your privacy. If you would like to read the more detailed version, please go to our website at www.ensomh.com, or ask any staff member for a copy. If you have questions about our practices, please let us know.

How we use and disclose your protected health information (PHI) with your consent

We need information about you and your condition to provide care to you. In almost all cases, we intend to use your PHI here or share it with other people or organizations to provide treatment to you, arrange for payment for our services, or some other business functions called "health care operations." We will ask you to sign a separate consent form (page 2 of this document) to show that you understand these ways we handle your information. If you do not agree and won't sign this consent form, we will not treat you. If we want to use or send, share, or release your PHI for other purposes, we will discuss this with you first, so you fully understand it, and ask you to sign a separate release of information form to allow it.

Disclosing your health information without your consent

There are some times when the laws require us to share your PHI without getting your consent first. They are described in the longer version of our Notice of Privacy Practices, but here are the most common situations:

- When there is a serious threat to your health or safety, or another person's health or safety, or to the public. We will only share information with people who are able to help prevent or reduce the danger.
- When we are required by law to do so through lawsuits and other legal or court proceedings.
- When a law enforcement official requires us to do so.
- For workers' compensation and some similar programs if you seek these benefits.

Your rights about your protected health information (PHI)

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, rather than 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 people involved in your care or with payment for your care, such as family members and friends.
3. You have the right to prevent our sharing your PHI with your insurer or payer for its decisions about your benefits or some other uses, if you paid us directly ("out of pocket") for the treatment and are not asking the insurer to pay for those services - unless we are under contract with your insurer (on their panel of providers).
4. You have the right to look at the PHI we have about you, such as your medical and billing records. In some very unusual circumstances, if there is very strong evidence that reading this would cause serious harm to you or someone else, you may not be able to see all of the information. You can get a copy of these records, and we can charge you for it.
5. f you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing.
6. If you have a problem with how your PHI has been handled, or if you believe your privacy rights have been violated, you have the right to file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington, DC 20201, or by calling 202-619-0257.
7. You have a right to a copy of this notice.

You may have other rights that are granted to you by the laws of South Dakota, and these may be the same as or different from the rights described above. Enso Mental Health, LLC staff will be happy to discuss these situations with you now or as they arise. The effective date of this notice is **1/12/2021**.

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Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____, and Enso Mental Health, LLC.
When we use the words "you" and "your" below, this can mean you, your child, or a person for whom you are the legal or personal representative if you have written his or her name here: _____.

When we examine, evaluate, 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 in our office to decide what treatment is best for you and to provide this treatment to you. We may also share this information with others to arrange payment for your treatment, to help others provide other treatment to you, or to carry out certain business or government functions.

By signing this form, you are agreeing to let us use your PHI here and to send it to others for the purposes described just above. Your signature below acknowledges that you have read or heard our Notice of Privacy Practices, which explains in more detail what your rights are and how we can use and share your information. If you do not sign this form agreeing to our privacy practices, we cannot treat you, because we need to use your PHI to evaluate, diagnose, and treat you.

In the future, we may change how we use and share your PHI, and so we may change our Notice of Privacy Practices. If we do change it, you can get a copy from our website [www.ensomh.com], or from Enso Mental Health, LLC staff.

After you have signed this consent, you have the right to revoke it by writing to our compliance officer. We will then stop using or sharing your PHI, but if we have already used or shared some of it, and we cannot change that.

_____ ___/___/___

Signature of client or personal representative — Date

_____ _____

Printed name — Relationship to client

_____

Signature of authorized representative of this office or practice

- ❑ Copy given to the client/parent/personal representative
- ❑ Copy declined by client/parent/personal representative

[1/12/2021]