Roz Davidovich, Psy.D

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Notice of Privacy Practices and Cancellation Policy

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS -- (PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) -- AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (**HIPAA**) HAS CREATED PATIENT PROTECTIONS SURROUNDING THE USE OF PROTECTED HEALTH INFORMATION. COMMONLY REFERRED TO AS THE MEDICAL RECORDS PRIVACY LAW, HIPAA PROVIDES PATIENT PROTECTIONS RELATED TO THE ELECTRONIC TRANSMISSION OF DATA, THE KEEPING AND USE OF PATIENT RECORDS, AND STORAGE AND ACCESS TO HEALTH CARE RECORDS. PROVIDERS AND HEALTH CARE AGENCIES ARE REQUIRED TO PROVIDE PATIENTS A NOTIFICATION OF THEIR PRIVACY RIGHTS AS IT RELATES TO THEIR HEALTH CARE RECORDS.
BY LAW, I AM REQUIRED TO OBTAIN YOUR SIGNATURE INDICATING YOU HAVE RECEIVED THIS DOCUMENT.

I. Confidentiality

I will not disclose information about you or the fact that you are my client, without your written consent or as mandated by law (see below). My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis, and progress. Healthcare providers are legally allowed to use or disclose records or "protected health information" (or PHI) for treatment, payment, and health care operations purposes. **However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form) or through your written authorization at the time the need for disclosure arises.** You may revoke your permission, in writing, at any time. In addition, I may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with and limited to relevant requirements of law. You will be notified, as required by law, of any such uses or disclosures of which I am aware.

II. Limits of Confidentiality

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality - some exceptions created voluntarily by my own choice and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its

limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together. I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy or because legally required:

- **Serious Threat to Health or Safety:** Under New York law, if I am engaged in my professional duties, and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety, as mandated by law.

- **Child Abuse Reporting:** If, in my professional opinion, a child comes before me which I have reasonable cause to suspect is an abused or maltreated child, or if I have reasonable cause to suspect a child is abused or maltreated where the parent, guardian, custodian or another person legally responsible for such child comes before me in my professional or official capacity and states from personal knowledge, facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child, I must report such abuse or maltreatment to the statewide central register of child abuse and maltreatment and/or the local child protective services agency.

- **Adult Abuse Reporting:** If I have reason to suspect that an elderly or disabled adult is abused, neglected or exploited, I am required by New York law to make a report and provide relevant information to the New York Adult Protective Services.

- **Emergency:** If you are involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

- **Health Oversight:** If there is an inquiry or complaint about my professional conduct to the New York State Board for Psychology, I must furnish to the New York State Commissioner of Education any PHI relevant to this inquiry.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.

- **Workers Compensation:** If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.
- **Electronic Communication**: Despite my best efforts to protect electronic communications (by password-protecting devices that are used for emails or text), there is a slight chance that such communication may be illegally accessed by an unauthorized individual. Therefore, even though the

risk is minimal, by signing this document you acknowledge that no communication via email or text will be considered completely confidential.

III. Patient's Rights

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of protected health information by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages. To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

Right to an Accounting of Disclosures: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section II of this Notice). On your written request, I will discuss with you the details of the accounting process.

Right to Amend: If you feel that your PHI is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing and submitted to me. Also, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

Right to a Copy of this Notice: You have the right to obtain a paper copy of this notice. You may ask me to give you a copy of this notice at any time.

IV. Cancellation Policy

All cancellations must be made at least 24 hours in advance of your scheduled session.

Patients who do not show up for their appointment or cancel on the same day (including for reasons such as illness or work conflicts) are expected to make an effort to reschedule prior to their next session. If rescheduling is not possible, a $135 cancellation fee will be required before the next appointment can be scheduled.

Please date this document and keep it for your records.

Effective Date: _____

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Patient's Acknowledgement of Receipt of Notice of Privacy Practices (pursuant to HIPAA) and Cancellation Policy

Please print your name, sign and date this acknowledgment form.

I have been provided a copy of the **Notice of Privacy Practices and Cancellation Policy**.

I have asked any questions I have regarding this document, and I understand that I may ask questions about it at any time in the future.

I ACCEPT THESE POLICIES AS A CONDITION OF RECEIVING MENTAL HEALTH SERVICES.

Printed Name: _____

Signature: _____

Date: _____