

*Serenity Counseling LCSW PLLC  
20 Medford Avenue Suite 109  
Patchogue, New York 11772  
Phone 704-458-3025  
fpredarrow1@gmail.com*

## Notice of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to ...

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain payments from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand the notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that a professional entity has the right to change its Notice of Privacy Practices from time to time and that I may contact that professional at the address above to obtain a current copy of this information.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

Client Name (please print): \_\_\_\_\_

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Name (please print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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You have the right:

- to be treated with dignity and respect.
- to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- to have your treatment and other patient information kept private. Only by law may records be released without patient permission.
- to access care easily and in a timely fashion.
- to a candid discussion about all your treatment choices, regardless of cost or coverage by the health benefit plan.
- to share in developing your plan of care.
- to the delivery of services in a culturally competent manner.
- to information about the organization, its providers, services and role in the treatment process.
- to information about provider work history and training.
- to information about clinical guidelines used in providing and managing your care.
- to know about advocacy and community groups and prevention services.
- to freely file a complaint, grievance, or appeal and to learn how to do so.
- to know about laws that relate to your rights and responsibilities.
- to know of your rights and responsibilities in the treatment process and to make recommendations regarding the organization's rights and responsibilities policy.

You have the responsibility:

- to treat those giving you care with dignity and respect.
- to give providers the information they need in order to provide the best possible care
- to ask your providers questions about their care.
- to help develop and follow the agree-upon treatment plans for your care, including the agreed upon medication plan.
- to let your provider know when the treatment plan no longer works for you.
- to tell your provider about medication changes, including medications given to you by others.
- to keep your appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- to let your provider know about your insurance coverage and any changes to it.
- to let your provider know about problems with paying fees.
- not to take actions that could harm others.
- to report fraud and abuse.
- to openly report concerns about quality of care.
- to let your provider know about any changes to your contact information (name, address, phone etc...)
- understand and help develop plans and goals to improve your health.

I have read and understand my rights and responsibilities.

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Patient/Client Print Name

Date

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Patient/Client Signature

Date

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Parent/Guardian Print Name

Date

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Parent/Guardian Signature

Date