

Notice of Privacy Practices

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NOTICE OF PRIVACY PRACTICES

Health Insurance Portability Accountability Act (HIPAA): Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a client and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.

3. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
4. If a client files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the client's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
6. I am licensed by the State of Arizona (license LMSW-17582) and under the direct clinical supervision of Tandie Myles, LCSW, as required by the Arizona State Board of Behavioral Health Examiners. If you ever want to contact her you can call (520) 314-1255. As required by the state, my supervisor must have access to client files.

There are some situations in which I am legally obligated to take actions, which are necessary to attempt to protect others from harm, and I may have to reveal some information about a client's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Arizona Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Arizona Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the client, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the client.

Psychotherapy Notes:

I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

1. For my use in treating you.
2. To comply with state supervision requirements.
3. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
4. For my use in defending myself in legal proceedings instituted by you.

5. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
6. Required by law and the use or disclosure is limited to the requirements of such law.
7. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes (i.e. supervision).
8. Required by a coroner who is performing duties authorized by law.
9. Required to help avert a serious threat to the health and safety of others.

CLIENT RIGHTS AND THERAPIST DUTIES Use and Disclosure of Protected Health Information:

- For Treatment – I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes. If you or your minor child is in a DBT skills group, I require parent/guardian sign a release of information form allowing me to consult with the minor child's individual therapist.
- For Payment – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Elements Counseling Financial Responsibility Statement.
- For Operations – I may use and disclose your health information as part of our internal operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you. I may use or disclose your health information to provide you with appointment reminders (such as phone or voice messages). In the case of a personal illness or emergency and I am unable to contact you, I may use or disclose your health information to request a colleague contact you in my stead to notify you of the illness or emergency, in order to cancel and or reschedule your appointment/s.

Client's Rights:

- Right to Treatment – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category. It may be necessary to refer you to another clinician if I lack the time and or skills to necessary to support you, or if we are not a good therapeutic fit.
- Right to Confidentiality – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information. When working with minors I will break confidentiality and inform parent/s if a minor admits to a recent suicide attempt, dangerous drug use (e.g. cocaine, opiates, fentanyl, etc.), risky sexual behavior, an eating disorder, or other behavior that endangers their life. I may also be a mandated reporter if a minor reveals they are in a sexual relationship with an adult over the age of 18, depending on

the age gap between the two.

- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- **Right to Inspect and Copy** – You have the right to look at or obtain copies of your health information, with limited exceptions. Records must be requested in writing and release of information must be completed. You may request that I provide copies in a format other than photocopies. I will use the format you request unless I cannot practicably do so. I will charge you a fee for expenses such as copy costs and copy/preparation time. You may also request access by sending me a letter to the address at the top of this Notice. If you request copies, I will charge you for my time (at my regular hourly rate), copy costs, and postage if you want the copies mailed to you. If you request an alternate format or a summary/explanation of your health information, I will charge my regular hourly fee for providing your health information in that format. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request. [***Note: In the event that your records are co-mingled (i.e. if you are a part of a Child Custody Evaluation, Family Court Case, family therapy, mediation, or marriage counseling), I need a signed consent by all parties involved in order to release records. Third party records in your file (i.e. doctors, other professionals, and references) have the right to confidentiality, and will not be released by this office unless ordered to do so by law. Please contact those professionals directly for records.]
- **Right to Amend** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- **Right to a Copy of This Notice** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- **Right to an Accounting** – You have the right to receive a list of instances in which I or my business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities as described above, for the last six years, but not before January 1, 2019. If you request this accounting more than once in a 12-month period, I may charge you a reasonable, cost-based fee for responding to these additional requests.
- **Right to Choose Someone to Act for You** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- **Right to Choose** – You have the right to decide not to receive services with me. If you wish, I will provide

you with names of other qualified professionals.

- **Right to Terminate** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- **Right to Release Information with Written Consent** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. I reserve the right to make the changes in my privacy practices and the new terms of my Notice effective for all health information that I maintain, including health information that I created or received before I made the changes. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

NATIONAL SECURITY: I may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. I may disclose to authorized federal officials health information required by lawful intelligence, counterintelligence, and other national security activities. I may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or client under certain circumstances.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Arizona Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR eSIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT, UNDERSTAND IT, AND AGREE TO ITS TERMS, AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.