Shane Elsdon, MS, NCC, LMHC
Art of Loving Center

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and RCW 70.02. 120)

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Shane Elsdon at his voice mail (425) 358-8558. Written requests should be made to the following address:

Art of Loving Center LLC.
Shane Elsdon, MS, NCC, LMHC.
40 Lake Bellevue Dr. Suite 250
Bellevue WA. 98005

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, as well as how you can access your information.

By my signature below I acknowledge receipt of the full Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

This notice describes your rights regarding your health information. Your health information includes notes created by me as a result of our sessions, insurance information for the purpose of payment, and any information I receive about you related to your past, present, and future health.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Shane Elsdon MS., NCC, LMHC at Art of Loving Center LLC is required to maintain the privacy of your protected health information, provide you with this notice of our legal duties and privacy practices with respect to your health information, and comply with the practices and procedures set forth in this notice.

Record Keeping Practices

Standard practice requires us to keep a record of your treatment. This includes a general description of your emotional and psychological functioning, a diagnosis (if you choose to bill your insurance company), goals of treatment, symptoms, medications, your progress, and homework assignments if given. This record of treatment is your protected health care information or "PHI". We may use or disclose your PHI for treatment, payment, and health care operation purposes.

How We May Use and Disclose Your Health Information WITHOUT Your Authorization

1. Uses and Disclosures for Treatment, Payment, and Health Care Operations

a. For Treatment. We may use and disclose your PHI without your authorization:

i. To your psychiatrist, other therapist, or nurse to provide coordinated health care and related services (e.g. we consult with another therapist or health care provider about your care)
ii. To another health care provider working outside of Shane Elsdon and Art of Loving Center LLC for the purposes of coordinating treatment and sharing information that will help your care (e.g. your primary care physician).

b. **For Payment**. We may use or disclose health information without authorization if you choose to bill a third party.

i. Disclosure of PHI to your health insurer to assist you in obtaining reimbursement or to determine eligibility of coverage.

c. **Health Care Operations.** We may use or disclose health information without your authorization:

i. To run the practice and make sure our clients receive quality care. Activities may include: quality assessment and improvement, reviewing our performance and qualifications, case management, accreditation, licensing, business planning and development, legal audits, and general administrative activities.

ii. In combination with information about other clients to decide what additional services we should offer, what services are no longer needed, and whether certain treatments are effective

Other Situations in Which We May Disclose Your Information WITHOUT Your Consent:

Emergencies: To assure good care in cases of emergencies. For example, we may provide health information to a paramedic who is transporting you in an ambulance.

Legal Guardian: To your guardian or fiduciary if one has been appointed by the court.
Required by Law: I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are: public health reports, law enforcement reports, abuse and neglect reports, and reports to coroners and medical examiners in connection with a death. I also must make disclosures to the Secretary of the U.S. Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.
Threat to Health or Safety: In the instance when you or someone else is in imminent danger of harm I may disclose your health care information for the purpose of safety.
Health Oversight: I may disclose your health care information to a health oversight agency for activities authorized by law, such as my professional licensure, audits, and investigations. Oversight agencies also include government agencies that oversee the health care system, organizations such as third-party payers, other government programs regulating health care, and civil rights laws.
Public Health Activates: We may use and disclose information about you when necessary for public health activities, to prevent or control disease, injury, or disability, or reporting to the Food and Drug administration for investigating or tracking problems with prescription drugs.
Abuse or Neglect: To government entities authorized to receive reports regarding abuse, neglect, or domestic violence (e.g. child abuse/neglect, elder/vulnerable adult abuse/neglect).
Criminal Activity: We may disclose your health care information to law enforcement officials for law enforcement purposes. For example, if you have committed a crime on our premises or against us, identify or locate a suspect, witness or missing person, to report a crime or to provide information concerning victims of crimes.
Business Associates: I may disclose your health care information to business associates with whom I contract to administer billing and/or legal services. My contract with them requires them to safeguard the privacy of your information.
Compulsory Process: I will disclose your personal health care information if a court of competent jurisdiction issues an appropriate order. I will disclose your health care information if you and I have Notice of Privacy Practices Page | 4 v 1.0 each been notified in writing at least fourteen days in advance of a subpoena or other legal demand, and no protective order has been obtained, and I have satisfactory assurances that you have received notice of an opportunity to have limited or quashed the discovery demand.
Department of corrections: If you are an inmate of a correctional institution or under the custody of a State of Washington Department of Corrections parole/probation officer, we may disclose information to the correctional institution or parole/probation officer.
Medical Examiners: We may provide health information to a medical examiner who is appointed by law to assist in identifying deceased persons and to determine the cause of death in certain circumstances.
National Security and Protective Services for the President and Others: We may disclose health information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law, and to authorized federal officials of state so they may conduct special investigations.

Uses and Disclosures That May Be Made WITHOUT Your Authorization, But for Which You Will Have an Opportunity to Object

1. Appointment Reminders

a. We may provide health information to you, to remind you in writing, or by phone/voicemail that you have an appointment with us, unless you specifically ask us to communicate with you through a different method.

Confidentiality of Information Related to STI's, AIDS, HIV

Information related to testing or treatment of HIV or sexually transmitted infections is protected by state law (RCW 70.24.15). Generally, we may not disclose a diagnosis or the results of the tests or treatment for HIV, AIDS, or sexually transmitted infections unless you have specifically authorized us to do so, except:

- **a.** When exchanging medical information with other health care providers
- **b.** For protection of public health (see as stated above)
- **c.** As required by court order after application showing good cause, or to claims management personnel state-administered health care claims payer, or any other payer of health care claims where such disclosure is to be used solely for the prompt and accurate evaluation and payment of medical or related claims.

Uses and Disclosures of Health Care Information WITH Your Written Authorization

We will make other uses and disclosures of your protected health care information only when your appropriate authorization is obtained. An "authorization" is written permission that permits specific disclosures (authorizations are in effect for 90 days). You may revoke this authorization in writing at any time; unless we have taken an action in reliance on the authorization of the use or disclosure you permitted, such as providing you with health care services for which we must submit information to an insurance company.

Your Rights Regarding Your Protected Health Information

You have the right to **inspect and copy** your PHI, which may be restricted in certain limited circumstances, for as long as we maintain it. We may charge you a reasonable cost-based fee for copies.

You have the right to **ask that we amend** your record if you feel the PHI is incorrect or incomplete. We are not required to amend it; however, you have the right to file a written statement of disagreement with us (any disagreement statement must contain why you believe the information is incorrect or inaccurate), to which we are allowed to prepare a rebuttal. Your request, your statement of disagreement, and our rebuttal will be maintained in your record. We may also deny the request to amend your health information if:

- **a.** It was not created by us, unless the person/entity that created the health information is no longer available to make the amendment
- **b.** It is not part of the health information we maintain to make decisions about your care
- **c.** It is not part of the health information you would be permitted to inspect or copy
- **d.** It is accurate and complete

You have the right to **request the required accounting of disclosures** we make regarding your PHI. This documents any non-routine disclosures made for purposes other than your treatment, payment, and health care operations. Any request should state the time period for which you wish to receive an accounting. The first accounting within a 12-month period is free. For additional requests during the same 12-month period, we will charge you. You may choose to modify or withdraw your request before we incur any costs.

You have the right to **request a restriction** or limitation on the use of your PHI for treatment, payment, or operations of my practice. We are not required to agree to your request, and we will not honor your request in instances where we believe it would compromise quality care (e.g. emergency treatment).

You have the right to **request confidential communication** with us. An example of this might be to send your mail to an alternate address or not call you at home. We will accommodate reasonable requests. You do not need to provide a reason for the request.

You have the right to **have a paper copy** of this notice.

Complaints

If you believe we have violated your privacy right you may file a complaint in writing to us and/or the U.S. Secretary of Health and Human Services. We will not retaliate against you for filing a complaint. To file a complaint with us contact me at 40 Lake Bellevue Dr. Suite 250 Bellevue WA. 98005 or call me at (425) 358-8558. All complaints must be submitted in writing.

Contact Information

I am my own Privacy Officer. If you have any questions about this Notice of Privacy Practices, please contact me at:

Art of Loving Center LLC.
Shane Elsdon, MS, NCC, LMHC
40 Lake Bellevue Dr. Suite 250
Bellevue WA. 98005
(425) 358-8558

Changes To This Notice

We reserve the right to change the terms of our Notice of Privacy Practices. We also reserve the right to make the revised or changed Notice of Privacy Practices effective for all health information we already have about you, as well as any health information we receive in the future, whether or not you are still in treatment with us. We will maintain a copy of the current Notice of Privacy Practices at our office. You may also obtain a copy of the current Notice of Privacy Practices by contacting the Privacy Officer and requesting a copy be sent to you or by asking for one any time you are at our office.

Therapist's Duties

This notice describes your rights regarding how you may gain access to and control your PHI and how we may use and disclose it. We are required by law to abide by the terms of this Notice of Privacy Practices and reserve the right to change the terms of this notice at any time.

Acknowledgement

We are required to request your acknowledgement that you received this notice. You will be asked to sign the **Acknowledgment of Receipt of Notice of Privacy Practices** at your initial session indicating you received and read through the above information.