Jessica Volpentesta, LMHC
Second Nature Counseling
Washington State Licensed Mental Health Counselor #LH60696495
16307 NE 83rd St. Ste. 207
Redmond, WA 98052
(425) 974-9171

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.

My commitment to your privacy

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private. These laws are complicated, but I must give you this important information. Please let me know if you have any questions about this form.

How I use and disclose your protected health information with your consent

I will use the information I collect about you mainly to provide you with **treatment**, to arrange **payment** for my services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice I will ask you to sign a **consent form** to let me use and share your information in these ways. If you do not consent and sign this form, I cannot treat you. If I want to use or send, share, or release your information for other purposes, I will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require me to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. I will only share information with persons who are able to help prevent or reduce the threat.
2. When I am required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires me to do so.
4. For workers' compensation and similar benefit programs.

Your rights regarding your health information

1. You can ask me to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home, and not at work, to schedule or cancel an appointment. I will try my best to do as you ask.
2. You can ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information I have about you, such as your medical and billing records. You can get a copy of these records, but I may charge you for it.
4. If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation. You have to make this request in writing. You must also tell me the reasons you want to make the changes.
5. You have the right to a copy of this notice. If I change this notice, I will post the new version on my website at www.sncounseling.com, and you can always get a copy of it from the privacy officer, Jessica Volpentesta, LMHC.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with both myself and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way. Also, you may have other rights that are granted to you by the laws of my state, and these may be the same as or different from the rights described above. I will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or my health information privacy policies, please let me know.

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Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me, When I use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls "protected health information" (PHI) about you. I need to use this information in my office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described 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 I can use and share your information.

If you do not sign this form agreeing to our privacy practices, I cannot treat you. In the future, I may change how I use and share your information, and so I may change my notice of privacy practices. If I do change it, you can get a copy by calling me at (425) 974-9171 or emailing me at jcvolpentesta@gmail.com.

If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, I promise to do as you asked. After you have signed this consent, you have the right to revoke it in writing. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and I cannot change that.

_____	_____
Signature of Client	Date
_____	_____
Printed Name of Client	Date
_____	_____
Signature of Parent/Guardian (if under 18)	Date
_____	_____
Printed name of Parent/Guardian	Relationship to the client