**PRECISION TRAUMA THERAPY CENTER, LLC**
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# NOTICE OF PRIVACY PRACTICES

This notice describes how your medical and mental health information may be used and disclosed and how you can access this information. Please review it carefully.

Precision Trauma Therapy Center, LLC is committed to protecting the privacy and confidentiality of your protected health information (PHI). This notice explains our legal duties and privacy practices regarding your health information as required by the Health Insurance Portability and Accountability Act (HIPAA).

## I. OUR LEGAL DUTY

Precision Trauma Therapy Center LLC is required by law to:

- Maintain the privacy of your protected health information.
- Provide you with this Notice of Privacy Practices describing our legal duties and privacy practices.
- Follow the terms of the notice currently in effect.
- Notify you if a breach occurs that may compromise the privacy or security of your information.

We reserve the right to change the terms of this notice at any time. Any updated notice will apply to all health information we maintain and will be made available upon request.

## II. HOW YOUR INFORMATION MAY BE USED & DISCLOSED

Your protected health information may be used or disclosed for the following purposes:

### a. TREATMENT

Your information may be used to provide, coordinate, or manage your mental health care and related services. This may include consultation with other healthcare providers involved in your care when appropriate and authorized.

### b. PAYMENT

Your information may be used to obtain payment for services provided. This may include submitting claims to insurance companies, verifying coverage, or providing information necessary for billing and reimbursement.

**c. HEALTHCARE OPERATIONS**

Your information may be used for activities necessary to operate the practice, such as quality assessment, administrative functions, record management, and professional consultation.

**d. APPOINTMENT REMINDERS & COMMUNICATION**

We may contact you by phone, secure messaging, email, or other agreed-upon communication methods to remind you of appointments or provide information related to your care.

**e. AS REQUIRED BY LAW**

Your information may be disclosed when required by federal, state, or local law.

## III. SITUATIONS WHERE DISCLOSURE MAY OCCUR WITHOUT YOUR AUTHORIZATION

There are certain situations where the law allows or requires disclosure of your information without your written authorization, including:

**a. RISK OF HARM**

If a client presents a serious and imminent risk of harm to themselves or others, the therapist may disclose necessary information to appropriate parties, including emergency services, law enforcement, or identified individuals, in order to protect safety.

**b. ABUSE OR NEGLECT**

Therapists are mandated reporters under Ohio law and are required to report suspected abuse or neglect of:

a. Children
b. Elderly individuals
c. Dependent or vulnerable adults

to the appropriate authorities.

c. **COURT ORDERS & LEGAL PROCEEDINGS**

If records are subpoenaed or ordered by a court of law, the therapist may be legally required to disclose relevant information. Reasonable efforts will be made to notify the client when possible.

d. **PUBLIC HEALTH OR LAW ENFORCEMENT ACTIVITIES**

When required for certain public health or law enforcement purposes as allowed by law.

## IV. USES AND DISCLOSURES THAT REQUIRE AUTHORIZATION

Other uses or disclosures of your protected health information will only occur with your written authorization. You may revoke your authorization at any time in writing, except to the extent that action has already been taken based on the authorization.

## V. YOUR RIGHTS REGARDING YOUR HELATH INFORMATION

You have the following rights regarding your protected health information:

**a. RIGHT TO ACESS**

You have the right to request access to and obtain a copy of your health records, with limited exceptions.

**b. RIGHT TO REQUEST AMENDMENTS**

You may request corrections or amendments to your health records if you believe the information is incorrect or incomplete.

**c. RIGHT TO REQUEST RESTRICTIONS**

You may request restrictions on how your information is used or disclosed. While we will consider your request, we are not always required to agree to it.

**d. RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS**

You may request that we communicate with you using specific methods or at specific locations.

**e. RIGHT TO RECEIVE A COPY OF THIS NOTICE**

You have the right to receive a paper or electronic copy of this notice at any time.

**f. RIGHT TO FILE A COMPLAINT**

If you believe your privacy rights have been violated, you may file a complaint without fear of retaliation.

Complaints may be submitted to:

**Precision Trauma Therapy Center, LLC**
Admin@precisiontraumattc.com

You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below, you acknowledge that you have received or have been offered a copy of the Notice of Privacy Practices for Precision Trauma Therapy Center LLC.

This acknowledgment does not mean that you agree with all policies described in the notice, but confirms that you have been provided access to this information.

Client Signature: _____ Date: _____

Printed Name: _____

Parent/Guardian (if applicable): _____

Provider Signature: _____ Date: _____