Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information (HIPAA)

We have a duty to protect the confidentiality of information about you. We are required to provide you with a Notice of Privacy Practices explaining the ways we may use and disclose your information. New Directions Counseling Center, LLC will follow the Notice. It will be followed by any professionals and staff affiliated with New Directions Counseling Center, LLC.

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

I may use or disclose your protected health information (PHI) for treatment, payment, and healthcare operations purposes with your consent. To help clarify what this means, explanations are provided.

Specific Examples Include:

- Emergency treatment
- Appointment reminders
- Auditing
- Worker's Compensation
- Disability
- Lawsuits and disputes
- Managed Care Networks
- Payment/Reimbursement
- Collection Agencies
- Protection against serious threat
- As required by law

Uses and Disclosures Requiring Authorization

I may use or disclose PHI when your appropriate authorization is obtained. For instances outside of treatment, payment, and healthcare operation, your authorization will be requested. Your "authorization" is your written permission for specific contact or transfer of information to occur with a specified individual/agency. I will request your authorization before releasing information including psychotherapy notes or evaluations. Psychotherapy notes are notes that I have made from our sessions or conversations that are not a part of your medical record. These notes have a greater degree of protection than your PHI.

You are able to give your authorization and you are able to revoke all authorizations at any given time. Revocation for each authorization must be given in writing. You cannot revoke authorization if the authorization has been relied upon for treatment or if it is necessary as a condition to obtain insurance coverage.

Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose your PHI without your consent or authorization in the following situations:

- **Child Abuse:** Reasonable cause to suspect a child is being abused will lead to a mandatory report to the appropriate authorities.
- **Adult and Domestic Abuse:** Reasonable cause to suspect a disabled adult or elderly person is being abused, has been neglected, or exploited will lead to a mandatory report to the appropriate authorities.
- **Health Oversight Activities:** If I am subject of an inquiry by the Georgia Board of Psychological Examiners, I may be required to disclose protected health care information regarding you in proceedings before the Board.
- **Judicial and Administrative Proceeding:** If you are involved in a court proceeding and a request is made about your professional services received, such information is privileged under state law, and will not be released without written consent or a court order. However, this privilege does not apply if you are being evaluated by a third party or where an evaluation is court ordered. You will be informed in advance if this is to be the case.
- **Serious Threat to Health or Safety:** If I determine that you present a serious danger of violence to yourself or another person, I may disclose information in order to provide protection against such danger to yourself or the intended victim.
- **Worker's Compensation/Disability:** I may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation, disability, or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Patient's Rights and Psychologist's Duties

Patient Rights:

- The right to request restrictions on certain uses of your information. However, I am not required to agree to a restriction that you request.
- The right to inspect and to copy certain information of PHI in my medical or billing records. I may deny your access under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- The right to request an amendment of your information for as long as it is maintained in your record. I may deny your request. Upon your request, I will discuss with you the amendment process.
- The right to an accounting of certain disclosures of your PHI. On your request, I will discuss with you the details of the accounting process.
- The right to a paper copy of the notice from me upon request even if you agreed to receive a notice electronically.

Psychologists' 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. 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 make this information available either by mail or by request for a review of this information.

Complaints

If you believe your rights have been violated, or you disagree with a decision I made about access to your records you may contact either partner in this practice, Christi Bartolomucci, Ph.D. or Judi-Lee Webb, Ph.D., CEDS at 770-293-1950. We encourage you to speak to us about your healthcare concerns. You may file a written complaint to the Secretary of the US Department of Health and Human Services. This address can be provided to you upon request.

I, the undersigned, acknowledge that I have received, read, and understand the ***"Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information"*** from ***New Directions Counseling Center, LLC***. This policy is required by law under Health Insurance Portability and Accountability Act (HIPAA).

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Signature of Client or Parent/Guardian Date

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Name of Client or Parent/Guardian (Please Print) Date

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Signature of Other Adult Party Date

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Name of Other Adult Party (Please Print) Date

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Name of Client if under 18 years of age Date

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Signature of Treating Provider Date