now & **NEXT** counseling

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NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU (AND/OR YOUR CHILD IF THEY ARE THE CLIENT) MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. CONFIDENTIALITY

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. Your file is a formal Mental Health Record which describes the services provided to you and contains the dates of our sessions, your diagnosis (if you have one), functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes, including providing a diagnosis and session dates to your insurance company. If more information is requested by your insurance company, I will request your permission through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. LIMITS OF CONFIDENTIALITY

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by my own choice such as those related to minors between the ages of 13 and 18, and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

- Emergency: If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.
- Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by New York State law to report the matter immediately to the Department of Social Services.

- Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by New York State law to report the matter immediately to the Department of Social Services.
- Health Oversight: Social workers may be required my law to report misconduct by another health care provider disclosed by you. By policy, I also reserve the right to report misconduct by health care providers of other professions.
- Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. Protections of privilege may not apply if I do an evaluation for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety: If I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person including to yourself, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect you or third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization.
- Workers Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.
- ****Records of Minors 1. CONSENT TO TREATMENT*:*** *"A minor who knowingly and voluntarily seeks mental health services can access treatment, including medication, without parental consent if any one of the following conditions applies:*
  - *A parent or guardian is not reasonably available to consent; or*
  - *Parental involvement would be detrimental to the course of treatment; or*
  - *The parent or guardian has refused to give consent and a physician determines that treatment is necessary and in the best interest of the minor.*

If none of these circumstances apply, New York law requires the consent of a parent or guardian for outpatient mental health treatment. A young person may meet with a mental health care provider without prior parental consent in order to determine whether the minor meets these guidelines. Any determination as to whether the above criteria are met should be documented in the minor's medical record." (NYCLU, *Teenagers, Health Care and The Law*)

- ****Records of Minors 2. CONFIDENTIALITY:** In New York State, when a minor consents to mental health care in a situation where a caregiver's permission is not required by law as listed above in Consent to Treatment, any information relating to treatment may not be disclosed without the minor's permission. *"In those cases where a parent gives consent [which is most outpatient mental health treatment], the parent is not guaranteed access to all information relating to the treatment. When a parent requests access to a minor's mental health records, minors 13 and older may be notified of the request. If the minor objects to disclosure, the provider can choose to deny the parent's request. Further, professional ethics*

generally dictate that specific details of therapy sessions not be disclosed without the consent of the patient." (NYCLU, *Teenagers, Health Care and The Law*)
- Additional rare instances where disclosure is required or allowed by law
- Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. PATIENTS RIGHTS AND PROVIDER'S DUTIES
- Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.
- 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. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.
- Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process.
- Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.
- Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.
- Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the

future. The notice will contain the effective date . A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

IV. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE 1/1/2022

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PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of **Now and Next Counseling's** Notice of Privacy Practices (HIPAA).

We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

Signature:_____

Printed name:_____

Date:_____

Signature of parent or guardian:_____

Printed name:_____

Date:_____