Your Path Forward Counseling
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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION.

Each time you visit a healthcare provider, including a provider of mental health services, a record of your visit is made that contains Protected Health Information (PHI). Typically, in addition to the date, time, duration and location of your visit, this record may contain information about your presentation/ symptoms/ diagnosis, treatment plan, treatment recommendations as well as information about the services you received during this visit. It may include information about the health care coverage you had at the time of receiving services.

This health record serves as the basis for planning your treatment, coordinating care between different providers involved in your care, as a legal document describing your care and services, and as verification for you and/or a third-party payer that services billed were provided to you. It can also be used to monitor progress and assure quality of services.

Understanding what information is part of your record and how, when, and why this information is used can help you make informed decisions regarding authorizing disclosure of this information to others. Unless required or allowed by State and Federal laws, rules and regulations, your protected health information will not be disclosed without your prior authorization.

It is the responsibility and legal obligation of *Lisa Sciarani, LCSW/Your Path Forward* to:

- Ensure that the protected health information (“PHI”) that your Therapist has created or received about you is protected and secured.
- Use or disclose your health information only in the manner described below.
- Give you this notice of your Therapist’s legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect. This notice is posted in the Documents section of your client portal.

II. HOW YOUR THERAPIST MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that your Therapist uses and discloses health information. Any use or disclosure of your health information will be limited to the

minimum information necessary to carry out the purpose of the use or disclosure. For each category of uses or disclosures, your Therapist will explain what she means and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways your Therapist is permitted to use and disclose information will fall within one of the categories.

Payment Functions/Health Care Operations
Your Therapist may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from me, determine plan responsibility for benefits and to coordinate benefits. Health information may be shared with government programs such as Medicare, Medicaid, or private insurance to manage your medical necessity of health care services, and determine whether a particular treatment is covered under your plan.

Your Therapist may use or disclose health information about you to carry out necessary managed care/insurance related activities. For example, such activities may include activities related to plan coverage, completing a medical review, quality assessment and improvement activities, handling and investigating complaints, fraud and abuse detection programs, and administration activities.

Treatment
Your Therapist may use or disclose health information about you to make appropriate and necessary referrals, receive necessary consultation/supervision, and to coordinate appropriate and effective care. Your Therapist may share your health information with emergency treatment providers when you need emergency services.

Required by Law/Public Health
Your Therapist may use or disclose health information about you as required by law. Examples include reporting PHI to your next of kin or another person involved in your care, or worker's compensation, or similar laws. Your health information may be reported to public health authority or other appropriate government authority authorized by law to collect information for purposes related to preventing and controlling disease, injury, or disability.

Health Oversight Activities
Your Therapist may use or disclose health information about you to health, regulatory and/ or oversight agencies during audits, investigations, inspections, licensure, and other proceedings related to oversight of the health care system. For example, an auditor might need access to your record to ensure that privacy laws were not violated.

Judicial and Administrative Proceedings
Your Therapist may use or disclose health information about you in response to a subpoena or court order in the course of administrative or judicial proceedings required by law (such as a lawsuit that you are involved in or licensure action), for payment purposes (such as collection action), or for purposes of litigation that relates to health care operations where your Therapist is a party to the proceeding.

Public Safety/Law Enforcement
Your Therapist may use or disclose health information about you to appropriate persons in order to prevent or lessen a serious or imminent danger or threat to the health or safety of a particular person or the general public or where there is great likelihood of violence. Your Therapist may disclose health information in order to report abuse and/or neglect of a minor, elderly person, or a person with a disability.

State Laws
Some of the uses and disclosures described in this notice may be limited in certain cases by applicable state laws that are more stringent than Federal laws or regulations, including disclosures related to mental health and substance abuse, alcohol and drug treatment, genetic testing, and HIV testing.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

Except as described in this notice, you Therapist may not use or disclose your health information without written authorization from you. Your authorization is necessary for most uses and disclosures of health information to third party individuals.

IV. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask your Therapist not to use or disclose certain PHI for treatment, payment, or health care operations purposes. Your therapist is not required to agree to your request, and she may say “no” if she believes it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How Your Therapist Sends PHI to You. You have the right to ask your Therapist to contact you in a specific way (e.g., home or office phone) or to send mail to a different address, and your Therapist will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than “session notes,” you have the right to get an electronic or paper copy of your medical record and other information that your Therapist has about you. Your Therapist will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and your Therapist may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures Your Therapist Has Made. You have the right to request a list of instances in which your Therapist has disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided her with an Authorization. Your Therapist will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list your Therapist will give you will include disclosures made in the last six years unless you request a shorter time. Your Therapist will provide the list to you at no charge, but if

you make more than one request in the same year, your Therapist will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that your Therapist correct the existing information or add the missing information. Your Therapist may say “no” to your request, but she will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.
8. The right to be notified in the event of a breach in accordance with federal requirements.

V. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on January 1, 2023. Your Therapist reserves the right to amend this notice of privacy practices at any time in the future to make the new notice provisions effective for all health information that it maintains. Your Therapist will provide you with a copy of the new notice.

VI. PRIVACY OFFICIAL/COMPLAINTS

If you believe your privacy rights have been violated, you may contact your Therapist directly as the privacy official or file a complaint with the Secretary of the Department of Health and Human Services at www.hhs.gov/ocr/privacy/hipaa/complaints/ .

VII. ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I (the client) have certain rights regarding the use and disclosure of my protected health information. By signing below, I am acknowledging that I have received and reviewed a copy of the HIPAA Notice of Privacy Practices.

_____ _____

Client Signature Date

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Parent/Legal Guardian Signature Date