



**NOTICE OF PRIVACY PRACTICES**

This notice describes how medical information about you may be used and disclosed and how you can get access to information. Please review it carefully.

I have been and always will be totally committed to maintaining client's confidentiality. I will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes office policies related to the use and disclosure of your healthcare information.

**USES AND DISCLOSURES OF YOUR HEALTHCARE INFORMATION FOR THE PURPOSE OF PROVIDING SERVICES:**

Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality healthcare. State and federal laws allow us to use and disclose you healthcare information for these purposes.

**TREATMENT:**

I may need to use or disclose health information about you to provide, manage, or coordinate your care or related services. Coordination of care might include consultations and potential referral sources.

**PAYMENT:**

Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims, as well as information needed for billing and collection purposes. I may bill the person, in your family, who pays for your insurance.

**HEALTHCARE OPERATIONS:**

I may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance, and licensing activities.

**OTHER USES OR DISCLOSURE OF YOUR INFORMATION, WHICH DOES NOT REQUIRE YOUR CONSENT:**

These are some instances where I may be required to use and disclose information without your consent. For example, but not limited to: information you and/or your child report about physical or sexual abuse, then by state law, we are obligated to report this to the Department of Children and Family Services; If you inform me that you are in danger of harming yourself or others; Information to remind you of/or to reschedule appointments or treatment alternatives; Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Print Name: \_\_\_\_\_ Signature \_\_\_\_\_

Client Name (if different from above): \_\_\_\_\_

Date: \_\_\_\_\_ Witness: \_\_\_\_\_