

# NOTICE OF PRIVACY PRACTICES

## EMPOWERING COUNSELING & THERAPY, LLC

Effective Date: MARCH 15, 2016



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

The privacy of your health information is very important to **EMPOWERING COUNSELING & THERAPY, LLC**, and we want to do everything possible to protect that privacy. We have an ethical and a legal responsibility under federal and state law to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice. Please feel free to ask for clarification about anything in this material.

Below are some examples of how we use and disclose information about your health information.

We may use or disclose your health information:

- To anyone on our staff involved in your treatment program. This includes paid and volunteer, clinical and administrative staff, on a need to know basis.
- To set-up and receive payment from you or from a third party payer (such as your insurance) for services we provide for you.
- To staff in connection with EMPOWERING COUNSELING & THERAPY LLC'S operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff, and improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.
- We also may disclose your health information to your physician or other healthcare provider who is also treating you.
- To professional business associates, such as a contracted medical billing agency. Business associates are expected and required to protect and safeguard our information with the highest professional standards.
- To anyone you give us written authorization to have your protected health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only effect the disclosure of your health information from that point on.
- To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects your health information that are necessary to respond to the emergency.

- To avoid harm or if you are a danger to yourself or others. We may provide your health information to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public. Disclosure is compelled or permitted if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if we determine that disclosure is necessary to prevent a threatened danger. Disclosure is mandated, if we have a reasonable suspicion of child abuse or neglect, or if we have a reasonable suspicion of elder abuse or dependent adult abuse or neglect. Disclosure is compelled or permitted by us if you tell us of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
- To any person required by federal, state, or local laws to have lawful access to your treatment program. These may include, but are not limited to, circumstances involving clients who are military personnel, cases involving worker compensation, or if there is the possibility of a public health risk.

We also may contact you for the purpose of setting up appointment, appointment reminders, to provide you with treatment alternative and health-related information, and as part of our fund-raising efforts. We will not use your protected health information in any of our Center's marketing, development, public relations, or related activities without your written authorization. We may use non-identifiable information, such as demographic and statistic information, in these ways. We will not use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

As a client of EMPOWERING COUNSELING & THERAPY LLC you have these important rights:

- A. With limited exceptions, you can make a written request to inspect your protected health information that is maintained by us for our use. You can ask us for photocopies of this information. We will charge you \$0.25 per page for making these photocopies.
- B. You have a right to a copy of this notice at no charge.
- C. You can make a written request to have us communicate with you about your health information by alternative means, such as by fax only, or at an alternative location, such as to your work place only. Your written request must specify the alternative means and location.
- D. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.
- E. You can make a written request that we amend any part of your health information. If we approve your written amendment, we will change or make addendums to our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing. If we deny your amendment we will do so in writing. You can place a written statement in our records disagreeing with our denial of your request.
- F. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes

other than for treatment, payment, or operations. This can go back as far as six years, but not before March 15, 2016. If you request this accounting more than once in a twelve month period we may charge you a fee based on our costs of tabulating these disclosures.

- G. If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing: EMPOWERING COUNSELING & THERAPY LLC, 1015 DELTA AVE., CINCINNATI OH 45208. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.

We encourage you to provide your therapist with any concerns or complaints you may have about our privacy practices. We will try to accommodate your concern as quickly as possible.

We have the right to change any of these privacy practices as long as those changes are permitted or required by law. Any changes in our privacy practices will effect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at EMPOWERING COUNSELING & THERAPY LLC. These changes could also affect how we protect the privacy of any of your health information we had before the changes.

When we make any of these changes, we will also change this notice and give you a copy of the new notice if you are an active client at the time of the change. When you are finished reading this notice, you may request a copy of it at no charge to you. If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you. If you have any questions or concerns about the material in this document, please ask us for assistance which we will provide at no charge to you. Our most current Notice of Privacy Practices is also posted in our office and on-line at [www.empoweringcounselingandtherapy.com](http://www.empoweringcounselingandtherapy.com) .



## Notice of Privacy Practices HIPAA Acknowledgement Form

Empowering Counseling & Therapy is required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of Empowering Therapy & Counseling's HIPAA Notice of Privacy Practices.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

I wish to retain a hard copy of Empowering Therapy & Counseling's HIPAA Notice of Privacy Practices for my records at this time.

I do not wish to retain a hard copy of Empowering Therapy & Counseling's HIPAA Notice of Privacy Practices for my records at this time.

### OO FOR OFFICE USE ONLY OO

Empowering Counseling & Therapy has made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.

Other (*Please provide specific details*): \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_