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STATE OF OHIO NOTICE FORM (HIPAA)

NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

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

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

We (the therapists at Cornerstone Counseling of Bellevue, LLC) may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes in most instances without your consent under HIPAA, but we obtain consent in another form.

To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another therapist.
- Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage, which would include an audit.
- Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within our practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of our practice group, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain a written authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy. Note, psychotherapy notes may not be required to be released for eligibility or underwriting purposes.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization as allowed by law, including, but not necessarily limited to, the following circumstances:

Child Abuse: If, in our professional capacity, we know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or mentally retarded/developmentally disabled child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, we are required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or other appropriate governmental agency.

Adult and Domestic Violence: If we have reasonable cause to believe that an elderly adult age 60 or over, or an adult mentally retarded/developmentally disabled person is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, we are required by law to immediately report such belief to the County Department of Job and Family Services and/or other appropriate government agency. If we believe that a patient or client has been the victim of domestic violence, we must note that knowledge or belief and the basis for it in the patient's or client's records.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release this information without written authorization from you or your personal or legally-appointed representative, or upon receipt of a court order. The privilege does not apply when you are being evaluated 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 we believe that you pose a clear and substantial risk of imminent serious harm, or a clear and present danger, to yourself or another person we may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to us an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and we believe you have the intent and ability to carry out the threat, then we may take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s). We will inform you about these notices and obtain your written consent, if we deem it appropriate under the circumstances.

Worker's Compensation: If you file a worker's compensation claim, we may be required to give your mental health information to relevant parties and officials.

IV. Patient's Rights Regarding Your Protected Health Information:

- **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request, except under certain limited circumstances.
- **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 one of us, so you may not want us calling your home and leaving a message on an answer machine. Upon your request, we will send your bills to another address and/or place calls to another number. If your request is reasonable, then we will honor it.
- **Right to Inspect and Copy.** You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record.
- **Right to Amend.** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- **Right to an Accounting.** 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 request, we will discuss with you the details of the accounting process. Accounting is only required to be kept for a six year period.
- **Right to a Paper Copy.** You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with this notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice and to make those changes effective for all the PHI we maintain.
- If we revise our policies and procedures, we will make available a copy of the revised notice to you on our website and you may always request a paper copy.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we make about access to your records, you may file a complaint with us and we'll consider how best to resolve your complaint. Contact our Privacy Officer, listed below, if you wish to file a complaint with us. In the event that you aren't satisfied with our response to your complaint, or don't want to first file a complaint with us, then you may send a written complaint to the:

Secretary of the U.S. Department of Health and Human Services in Washington, D.C.

or to:

Region V, Office for Civil Rights

U.S. Department of Health and Human Services

233 N. Michigan Ave., Suite 240 Chicago, IL 60601.

Ph. (312) 886-2359, Fax (312) 886-1807, TDD (312) 353-5693.

There will be no retaliation against you for filing a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on March 27, 2017.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will make

available a copy of the latest version on our website, or, upon your request, we will provide it in writing to you via U.S. mail.

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SIGNATURE SHEET

I have received, understand and agree to the provisions of a copy of the Notice of Privacy Practice for the office of Christopher Kaepner, Ph.D.

Client Name

Date of Birth

Signature of Patient, Parent or Guardian

Relationship

Date