

Notice of Privacy Practices

- Our practice is dedicated to maintaining the privacy of your personal health information. We are required by law to do this. These laws are complicated, but we must provide you with important this information. Please read it carefully. However, we cannot cover all possible situations so please feel free to talk to your therapist about any questions or problems you may have.
- We will use the information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for our services or for some other business activities which are called health care operations. After you read this Notice of Privacy Practices we will ask you to sign a Consent Form to let us use and share your information.

Your rights regarding your health information

- You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home and not a work to schedule or cancel appointments. We will try our best to do as you ask.
- You have the right to ask us to limit what we tell certain individuals involved in your care or the payment of your care, such as family members and friends. While we don't have to agree to you request, if we do, we will keep our agreement except if it is against the law, or in an emergency or when the information is necessary to treat you.
- You have the right to look at the health information we have about you such as your medical and billing records and therapy notes. You can even get a copy of these records but we may have to charge you for this.
- If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (call amending) to your health information. You have to make this request in writing and send it to our Office. You must tell us the reasons you want to make these changes.
- You have the right to a copy of this notice.
- You have the right to file a complaint if you believe your privacy rights have been violated. You can file that complaint with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Your signature below indicates that you have read and understand our privacy practices and have received a copy of our client rights brochure.

Client Signature: _____ Date: _____

Please print your name: _____

Duty to Warn Notice

We will keep your health information private but there are circumstances when we are required by law to share it. They are as follows:

1. Suicidal or homicidal thoughts or intentions. These are to keep you and others safe and protected.
2. Child, elder or dependent adult abuse or neglect.
3. Some lawsuits, legal or court proceedings.
4. If a law enforcement official requires it.
5. For Workers Compensation and similar benefit programs.

Before sharing any information with an outside source the therapist will make reasonable effort to inform the client first.

If a family or couple is seen in counseling together, they are viewed as one client. All information will be shared with all family members involved in therapy. Information about couples counseling or family therapy will not be shared with any outside source unless the listed conditions above exist. We will not provide any information for a court proceeding unless explicitly directed to do so by the court.

Your signature below indicates that you have read and understand that New Hope Counseling Center is required by law to share confidential and personal information if any of the listed conditions are present.

Client signature: _____ Date: _____

Print name _____

Therapist: _____ Date: _____

Print Name: _____