

GS Notice of Privacy Practices

GUIDING STEPS COUNSELING AND CONSULTATION SERVICES

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EFFECTIVE DATE OF THIS NOTICE This notice went into effect on June 6th, 2022.

NOTICE OF PRIVACY PRACTICES

Acknowledgement of receipt of Privacy Practice

Under the Health Insurance Portability and Accountability Act of 1996 (hereafter, "HIPAA"), you have certain rights regarding the use and disclosure of your protected health information (hereafter, "PHI").

Guiding Steps will maintain a clinical record of your case, which is the property of Guiding Steps. This includes your **protected health information (PHI)**. In most situations, Guiding Steps can release your PHI to others only if you permit us to do so by signing a written authorization form (release of information). However, there are situations in which we are permitted to use and disclose your PHI for the purposes of treatment, payment, and healthcare operations.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your PHI for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your PHI, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your health condition. During the consultation, every efforts is made to avoid revealing identity of clients. The other licensed professionals are also legally bound to keep the information confidential. I may also use your PHI for operations purposes, including sending you appointment reminders, billing invoices and other documentation. Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

- Your therapist may work with a billing specialist where information may be shared only for purpose such as billing, scheduling, and quality insurance.
- Your health insurance has the right to review your clinical record for any services you have asked them to pay for. Insurers are entitled to see PHI in your record, including information about dates of therapy, symptoms, your diagnosis, your overall progress towards those goals, any past treatment records, and any reports that have been sent to anyone, including reports to your health insurance company.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about you or your minor child(ren) in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts

have been made to tell you about the request or to obtain an order protecting the information requested.

USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION.

- When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
- For public health activities, including reporting suspected child, elder, or dependent adult abuse or neglect, suspected neglect or abuse of an animal, or preventing or reducing a serious threat to anyone's health or safety.
- For health oversight activities, including audits and investigations.
- For judicial and administrative proceedings, including responding to a court or administrative order or subpoena, although my preference is to obtain an Authorization from you before doing so if I am so allowed by the court or administrative officials.
- For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

1. **For my use in treating you.**
2. **For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.**
3. **For my use in defending myself in legal proceedings instituted by you.**
4. **For use by the Secretary of the Department of Health and Human Services (HHS) to investigate my compliance with HIPAA.**
5. **Required by law and the use or disclosure is limited to the requirements of such law.**
6. **Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.**
7. **Required by a coroner who is performing duties authorized by law.**
8. **Required to help avert a serious threat to the health and safety of others.**

MARKETING PURPOSES.

- I will not sell your PHI.

CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

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 me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe 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 I Send PHI to You.** You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I 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 I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I 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 I correct the existing information or add the missing information. I may say "no" to your request, but I 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 Choose Someone to Act For You. If you have given someone medical power of attorney or if someone is your legal guardian, that person can make choices about your health information.
9. The Right to Revoke an Authorization.
10. The Right to Opt out of Communications and Fundraising from our Organization.
11. The Right to File a Complaint. You can file a complaint if you feel I have violated your rights by contacting me using the information on page one or by filing a complaint with the HHS Office for Civil Rights located at 200 Independence Avenue, S.W., Washington D.C. 20201, calling HHS at (877) 696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints. I will not retaliate against you for filing a complaint.

CHANGES TO THIS NOTICE

I can change the terms of this Notice, and such changes will apply to all the information I have about you. The new Notice will be available upon request, in my office and on my website.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.