Notice of Privacy Practices

** indicates a required field*

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how health information about you is protected, and also how it may be used and disclosed. During the process of providing services, Transforming Through Therapy, PLLC, will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily, that information is confidential and will not be used or disclosed, except as described below.

USES, DISCLOSURES, AND COMMUNICATION OF PROTECTED INFORMATION

A. General Uses and Disclosures Not Requiring the Patient's Consent.
1. Treatment: Treatment refers to the provision, coordination, or management of healthcare (including mental healthcare) and related services. During treatment, the provider may consult with other providers, without identifying you by name, and also not disclosing any other identifying information about you, in order to ensure the best care possible for your concerns.

2. Payment: Payment refers to the activities undertaken by the provider to obtain or provide reimbursement for the provision of healthcare. For example, the provider will use your information to develop accounts receivable information, to bill you, and with your consent, to bill third parties. If you elect to have a third party pay for your treatment, the information provided to the third party may include information that identifies you as well as your diagnosis, type of service, date of service, and other information about your condition and treatment.

3. Contacting the Patient: The provider may contact you to remind you of appointments, or to change or cancel appointments. The provider may leave messages on voicemail or with other parties, identifying the name and phone number of the provider. The provider will use best judgment in the details left on a voicemail. If you do not want the provider leaving messages, or if you wish to restrict messages in any way, please notify the provider in writing.

4. Required by Law: The provider will disclose protected health information when required by law or when necessary for healthcare oversight. This includes, but may not be limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or take action regarding imminent danger to others; (d) when the patient is a danger to self, others, or is gravely disabled, or (e) reporting elder abuse or dependent person abuse.

5. Family Members: Except for certain minors, protected health information cannot be provided to family members without the patient's consent. In situations where family members are present during a discussion with the patient, and it can be reasonably inferred from the circumstances that the patient does not object, information may be disclosed in the course of that discussion. However, if the patient objects, protected health information will not be disclosed.

6. Emergencies: In life-threatening emergencies, the provider will disclose information necessary to avoid serious harm or death.

B. Patient Authorization or Release of Information:
The provider may not use or disclose protected information in any other way without a signed authorization or release of information. When you sign an authorization, or a release of information, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent the provider has already taken action in reliance thereon.

C. Alternative Means of Receiving Confidential Information:
You have the right to request that you receive communications of protected health information from the provider by alternative means or at alternative locations. For example, if you do not want the provider to mail statements or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests. You will also have to pay any additional costs that may be associated with such a request.

Protection of Confidential Information: The provider has taken steps to protect the confidentiality of your information, including the use of name-codes, password protection of computer files, locked file cabinets, paper shredding, and other security measures. Your files will be destroyed (shredded or incinerated) when past the time required for the maintenance of such records (e.g. 7 years after termination of therapy or 7 years after the client turns 18, whichever is later).

Statement of Understanding

I understand that a documented diagnosis is required to utilize health insurance and that my insurance policy may have varying procedures or limitations in coverage depending on the diagnosis rendered. I understand that some services may NOT be reimbursed or covered by health insurance and that I am ultimately financially responsible for all charges incurred. I understand that I am required to furnish Transforming Through Therapy, PLLC with information regarding changes in my health insurance status or eligibility as soon as they occur.

While your signature does not bind you to therapy, it does make you responsible for all charges incurred prior to termination (i.e., the end of treatment). If you are not able to honor your financial commitment, this may be grounds for therapeutically discussing financial issues, renegotiating the therapeutic contract, exploring alternative options, and/or ending treatment. If you are not able to make a payment after a session, you may ask for an extension. You agree to make every effort to remit payment within the agreed upon time frame. More than 3 unpaid sessions accumulated at any one time will necessitate a discussion of next steps.

Session Recording

Informed consent is mutual in the therapeutic relationship. Therapists do not record any portion of the session, nor do they share any information about you without your express written and/or verbal consent. Clients are prohibited from recording sessions, in whole or in part, at any time throughout the therapeutic relationship.

*** I hereby acknowledge that I have received a copy of the provider's Notice of Privacy Rights. Client's Signature (eSignature serves as legal signature)** _____

I consent to sharing information provided here.

*** Today's Date**