Ruth Graham, MA LMHC
Child, Adolescent, Adult & Family Therapist
DBA Hope Counseling Centers

NOTICE OF PRIVACY PRACTICES

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.

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION
You have the following rights regarding protected health information I maintain about you:

Right of Access to Inspect and Copy: You have the right, which may be restricted only in certain limited circumstances, to inspect and copy private health information that may be used to make decisions about your care. I may charge a reasonable, cost-based fee for copies.

Right to Amend: If you feel that the protected health information I have about you is incorrect or incomplete, you may ask me to amend the information, although I am not required to agree to the amendment. If your request to amend your health information has been denied, you will be provided with an explanation of my denial reason(s) and information about how you can disagree with the denial.

Right to an Accounting of Disclosures: You have the right to request a copy of the required accounting of disclosures that I make of your protected health information.

Right to Request Restrictions: You have the right to request a restriction or limitation on the use of your protected health information for treatment, payment, or health care operations. I am not required to agree to your request.

Right to Request Confidential Communication: You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

Right to Copy of this Notice: You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Right of Complaint: You have the right to file a complaint in writing with me or with the Secretary of Health and Human Services if you believe I have violated your privacy rights. I will not retaliate against you for filing a complaint.

MY USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

Treatment: Your protected health information may be used and disclosed by me for the purpose of providing, coordinating, or managing your health care treatment and any related services. This may include coordination or management of your health care with a third party, consultation with other health care providers or referral to another provider for health care services.

Payment: I may use and disclose Health Information so that others or I may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, I may give your health plan information about you so that they will pay for your treatment.

Healthcare Operations: I may use or disclose, as needed, your protected health information in order to support the business activities of my professional practice. Such disclosures could be to others for health care education, or to provide planning, quality assurance, peer review, administrative, level or financial services to assist in the delivery of health care, provided I have a written consent requiring the recipient(s) to safeguard the privacy of your protected health information. I may also contact you to remind you of your appointments, inform you of treatment alternatives and/or health-related products or services that may be of interest to you.

OTHER USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

Required by Law: I may use or disclose your protected health information: to the extent that the law requires the use or disclosure, made in compliance with the law, and limited to the relevant requirements of the law. Examples are public health reports and law enforcement reports. I also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

To Avert a Serious Threat to Health or Safety: I may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. I may disclose Health Information to my business associates that perform functions on my behalf or provide me with services if the information is necessary for such functions or services. For example, I may use another company to perform billing services on my behalf. All of my business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Health Oversight: I may disclose protected health information to a health oversight agency for activities authorized by law such as professional licensure. Oversight agencies also include government agencies and organizations that provide financial assistance to me (such as third-party-payers).

Abuse or Neglect: I may disclose your protected health information to a state or local agency that is authorized by law to receive reports of abuse or neglect. However, the information I disclose is limited to only that information which is necessary to make the initial mandated report.

Deceased Persons: I may disclose protected health information regarding deceased patients for the purpose of determining the cause of death, in connection with the laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

Research: I may disclose protected health information to researchers if (a) an Institutional Review Board reviews and approves the research and an authorization or a waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your protected health information; and (c) the researchers agree to maintain the security of your protected health information in accordance with applicable laws and regulations.

Criminal Activity on My Business Premises / Against My Staff and Me: I may disclose your protected health information to law enforcement officials if you have committed a crime on my premises or against my staff or me.

Compulsory Process: I will disclose your protected health information if a court or competent jurisdiction issues an appropriate order. I will disclose your protected health information if you and I have each been notified in writing at least thirty (30) days in advance of a subpoena or other legal demand, and no protective order has been obtained, I have satisfactory assurances that you have received notice of an opportunity to have limited or quashed the discovery demand. I may disclose your health information for military, national security, prisoner, and government benefits purposes.

Law Enforcement: I may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Change in Ownership: In the event that Hope Counseling Centers is sold or merged with another organization, your health information/record will become the property of the new owner.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION WITH YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization. You May revoke this authorization in writing at any time, unless I have taken an action in reliance on the authorization of the use or disclosure you permitted, such as providing you with health care services for which I must submit subsequent claim(s) for payment.

THIS NOTICE: This Notice of Privacy describes how I may use and disclose your protected health information in accordance with all the applicable law. It also describes your rights regarding how you may gain access to and control your protected health information. I am required by law to maintain the privacy of protected health information and to provide you with notice of my legal duties and privacy practices with respect to protected health information. I am required to abide by the terms of this Notice of Privacy Practices. I

reserve the right to change the terms of my Notice of Privacy Practices at any time. You will be provided with any new Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

COMPLAINTS: Complaints about your Privacy Rights, or how Hope Counseling Centers has handled your health information should be directed to Hope Counseling Centers by calling 206-605-0664. You may also make an appointment for a personal conference in person or by telephone and I will respond within 2 working days.

If you are not satisfied with the manner in which your complaint is handled, you may submit a formal written complaint to:

Secretary of the Department of Health and Human Services
Office of Civil Rights, US DHHS
2201 6th Avenue, MS RX-11
Seattle, WA 98121-1831

The quality of your care will not be jeopardized nor will you be penalized for filing a complaint.

CLIENT RIGHTS AND RESPONSIBILITIES

As a client of Hope Counseling Centers, you have the right to:

- Be treated with respect, dignity and privacy.
- Be informed in understandable language about the available treatment options and alternatives, and participate in the decisions for a plan of care and services, which meets your unique needs, and to refuse any proposed treatment.
- Receive care that does not discriminate against you, is free of any sexual exploitation or harassment, and is sensitive to your gender, race, national origin, language, age disability, and sexual orientation.
- Review your clinical record and be given any opportunity to make amendments or corrections.
- Have all information and records compiled, obtained, or maintained in the course of receiving services kept confidential.
- Voice questions, concerns, or complaints about any aspect of coverage, care, or service with your therapist, or if you are not satisfied to contact the Department of Health, Health Professionals Quality Assurance Division.
- Expect that all concerns and complaints will be addressed in a professional and non-punitive manner.

As a client of Hope Counseling Centers, you have the responsibility to:

- Provide Hope Counseling Centers with a complete and accurate health and family history.
- Participate in your care by asking questions and expressing concerns.
- Treat personnel, other clients, and property with respect and consideration. Refrain from using profanity in the common areas of the facility. Bring no weapons to your appointments.

- Notify Hope Counseling Centers of appointment cancellations with at least 24 hours in advance.
- Be on time for appointments.
- Maintain supervision of your children in the waiting areas or make arrangements for their supervision. Do not leave them unattended. No childcare is available during sessions.
- Notify Hope Counseling Centers of changes in your income or household size that could affect scholarship status.

ACKNOWLEDGEMENT OF YOUR UNDERSTANDING OF CONFIDENTIALITY AND PRIVACY PRACTICES: A paper copy will be provided upon request.

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Client Signature Date Parent/Guardian Signature Date

_____ _____

Client printed name Parent/Guardian printed name

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Clinician Signature Date