BeLight Holistic Psychotherapy & Wellness, PLLC

Notice of Privacy Practices
Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

PER THE HIPAA ACT OF 1996, I HAVE A LEGAL DUTY TO SAFEGAURD YOUR PROTECTED HEALTH INFORMATION. I will protect the privacy of the health information that I maintain that identifies you, whether it deals with the provision or payment of your health care. I must provide you with this Notice about my privacy practices. It explains how, when, and why I may use and disclose your health information. With some exceptions, I will avoid using or disclosing any more of your health information that is necessary to accomplish the purpose of the use and disclosure. I am legally required to follow the privacy practices that are described in this Notice, which is currently in effect.

However, I reserve the right to change the terms of this Notice and my privacy practices at any time. Any changes will apply to any of your health information that I already have. Before I make an important change to our policies, I will promptly notify you of changes.

I would like to take this opportunity to answer some common questions concerning my privacy practices:

QUESTION: HOW WILL BELIGHT HOLISTIC PSYCHOTHERAPY & WELLNESS, PLLC USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION?

Answer: I use and disclose health information for many different reasons. For some of these uses or disclosures, I need your specific authorization. Below, I describe the different categories or uses and disclosures and give you some examples of each.

A. Uses and Disclosures Relating to Treatment, Payment, or Healthcare Operations. I may, by federal law, use and disclose your health information for the following reasons.

1. For Treatment: For example, I may disclose your healthcare provider or agency related to linkage or referral, to a residential care program to which I am referring you. Reasons for such a disclosure may be: to get them medical history information they need to appropriately treat your condition, to coordinate your care, or to schedule necessary testing. With the possible exception of information concerning drug/alcohol abuse and/or treatment, and HIV status (for which we may need your specific authorization), we may disclose your health information to other health care providers who are involved in your care.

2. To Obtain Payment for Treatment: For example, I may provide certain portions of your health information to your health insurance company or managed care entity, in order to get paid for taking care of you. With the possible exception of information concerning drug and alcohol abuse and HIV status (for which we may need your specific authorization), I may use and disclose necessary health information in order to bill and collect payment for the treatment that I have provided to you.

B. Certain Other Uses and Disclosures are Permitted by Federal Law. I may use and disclose your health information without your authorization for the following reasons:

1. When a Disclosure is Required by Federal, State, or Local Law, in Judicial or Administrative Proceedings, or by Law Enforcement. For example, I may disclose your protected health information if ordered to do so by a court, or if a law requires that I report that sort of information to a government agency or law enforcement authorities, such as in the case of suspected child abuse.

2. For Public Health Activities. Under the law, I need to report information about certain diseases and about any deaths to government agencies that collect that information. With the possible exception of information concerning HIV status (for which we may need your specific authorization), we are also permitted to provide some health information to the coroner or a funeral director, if necessary, after a client's death.

3. To Avoid Harm. If I believe that it is necessary to protect you, or to protect another person or the public as a whole, I may provide protected health information to the police or others who may be able to prevent or lessen the possible harm.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to Family, Friends, or Others Involved in Your Care. I may provide a limited amount of your health information to a family member, to friends, or to another person known to be involved in your care or in the payment for your care, unless you tell me not to. For example if a family member or friend comes with you to your appointment and you allow them to come into the treatment room with you, I may disclose otherwise protected health information to them during the appointment unless you tell us not to.

2. Disclosures to Notify a Family Member, Friend, or Other Selected Person. When you first started in our program, we asked that you provide us with an emergency contact person in case something should happen to you while you are at our facilities. Unless you tell us otherwise, we will disclose limited health information about you (your general condition, location, etc.) to your emergency contact or another available family member, (for example, should you need to be admitted to the hospital).

D. Other Uses and Disclosures Require Your Prior Written Authorization.

In situations other than those categories of uses and disclosures mentioned above, or those disclosures permitted under federal law, I will ask for your written authorization before using or disclosing any of your protected health information.

If you choose to sign an authorization to disclose any of your health information, you can later revoke it to stop further uses and disclosures to the extent that I haven't already taken action relying on the authorization, so long as it is revoked in writing (except for people receiving drug and alcohol services, when a verbal revocation is accepted).

QUESTION: WHAT RIGHTS DO I HAVE CONCERNING MY PROTECTED HEALTH INFORMATION?

Answer: You have the following rights with respect to your protected health information:

The Right to Request Limits on Uses and Disclosures of Your Health Information. You have the right to ask me to limit how I use and disclose your health information. I will certainly consider your request, but you should know that I am not required to agree to it. If I do agree to your request, I will put the limits in writing and will abide by them, except in the case of an emergency. Please note that you are not permitted to limit the uses and disclosures that I am required or allowed by law to make.

The Right to Choose How I Send Health Information to You or How I Contact You. You have the right to ask that I contact you at an alternate address or telephone number (for example, sending information to your work address instead of your home address) or by alternate means. I must agree to your request so long as I can easily do so.

The Right to See or Get a Copy of Your Protected Health Information. In most cases, you have the right to look at or get a copy of your health information that I have, but you must make the request in writing. I will respond to you within 30 days after receiving your written request. If I do not have the health information that you are requesting, but I do know who does, I will tell you how to get it. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial. In certain circumstances, you have a right to appeal the decision.

If you request a copy of any portion of your protected health information, I will charge you for the copy on a per page basis, only allowed under State Law. I need to require that payment be made in full before I will provide the copy to you. If you agree in advance, I may be able to provide you with a summary or an explanation of your records instead. There may be a charge for the preparation of the summary explanation, including charge for staff time to develop the summary.

The Right to Ask to Correct or Update Your Health Information. If you believe that there is a mistake in your health information or that a piece of important information is missing, you have a right to ask that I make an appropriate change to your information. You must make the request in writing, with the reason for your request, on a request form that is available at your location of service.

I will respond within 60 days of receiving your request. If I approve your request, I will make the change to your health information, tell you when I have done so, and will tell others that need to know about the change.

I may deny your request if the protected health information: (1) is correct and complete; (2) was not created by me; (3) is not allowed to be disclosed to you; or (4) is not part of my records. My written denial will state the reasons that your request was denied and explain your right to file a written statement of disagreement with the denial.

QUESTION: HOW DO I COMPLAIN OR ASK QUESTIONS ABOUT THIS PRIVACY PRACTICE?

Answer: If you have any questions about anything discussed in this notice or about any of my privacy practices, or if you have any concerns or complaints, please contact your worker, who will direct you to the appropriate person. You also have the right to file a written complaint with the Secretary of the U.S Department of Health and Human Services. I cannot take any retaliatory action against you if you lodge any type of complaint.

QUESTION: WHEN DOES THIS NOTICE TAKE EFFECT?

Answer: This notice takes effect on April 14, 2003

Uses and Disclosures of PHI with Your Written Authorization:

We will make other uses and disclosures of your PHI only with your written authorization. You may revoke the authorization in writing at any time, unless we have taken a substantial action in reliance on the authorization such as providing you with health care services for which we much submit subsequent claim(s) for payment.

BeLight Holistic Psychotherapy & Wellness, PLLC

I have read and understand the HIPAA policies and understand that I can receive a copy if requested.

_____

(Client's Printed Name)

_____

(Client's Parent/Guardian Print Name if minor)

_____

Client's Signature (Client's Parent/Guardian if under 18)

_____

Today's Date

Witness: _____ Date: _____