4041 Ruston Way Suite 202 Tacoma, WA 98402 | 253-254-6681

Notice of Privacy Practices

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This notice describes how personal health information about you may be used and disclosed, as well as how you can get access to this information. Please review this Notice carefully as written acknowledgement that you have received this information is required by law.

Purpose

As a client in counseling, you have certain rights that are important for you to know about. There are also specific limitations to those rights which are equally important to understand. This Notice explains my Privacy Practices and how I protect your Personal Healthcare Information (PHI) according to both Washington State laws and federal regulations (HIPPA). Because this is a legal document required by HIPPA regulations, it includes legal terms specified in federal law.

Record Keeping Practices

Standard practice requires me to keep an official record of your therapy session(s). This may include a general description of your emotional or psychological functioning, a diagnosis (if required for insurance purposes), agreed-upon treatment goals, a list of symptoms, any medications, and some description of your progress throughout the time we work together.

Your Rights Relating to Your Personal Healthcare Information

You have specific legal rights relating to your personal healthcare information. I am required by law to maintain the privacy of your information and to provide you with this document describing my legal duties and privacy practices with respect to the information I maintain about you. As a client of a mental health therapist in WA State, you have privileged communications under the law. You also have the following rights:

1. You have the right to have your personal information kept confidential under RCW 18.19.180 of the WA state code.
2. You have the right (which may be restricted only in certain limited circumstances) to inspect and receive a copy of your personal healthcare information as long as I maintain it. I am permitted a reasonable, cost-based fee for copies.
3. You have the right to request that I amend your personal healthcare information if you believe that it is incorrect or incomplete. Requests must be made in writing and along with my response will become an official part of your healthcare record.
4. You have the right to request reasonable restrictions on certain uses and disclosures of your healthcare information for purposes of treatment, payment, or operations of my practice.
5. You have the right to request confidential communications from me by alternative means or at an alternative address.
6. You have the right to receive a copy of the required accounting of disclosures that I make of your personal healthcare information. This accounting documents non-routine disclosures or those made for purposes other than treatment, payment, or operations of my practice. It also excludes

disclosures I may have made to you or disclosures made at your request and accompanied by a specific written authorization of disclosure.

6. You have the right to obtain a paper copy of this Notice.

If you believe your privacy rights have been violated by me, you have the right to file a written complaint with me and/or you may file a complaint with the Secretary of the Department of Health & Human Services through the Health Professions Quality Assurance Division at (360)236-4900 or write to the Department at P.O. Box 47869, Olympia, WA 98504. I will not retaliate against you for filing such a complaint.

Uses & Disclosures of Your Healthcare Information

1. I may use your personal healthcare information for the purpose of providing you treatment.
2. I may use your healthcare information in connection with billing and payment, and in my system for tracking charges and credits to your account. With your authorization, I may disclose your information to third party payers to obtain information concerning benefit eligibility, coverage, and remaining availability, as well as to submit claims for payment and disclose your healthcare information for medical necessity and quality assurance review.
3. I may use and disclose your personal healthcare information for the healthcare operations of my practice in support of the functions of treatment and/or payment. Such disclosures would include those for administrative, legal, or financial services to assist me in providing your healthcare treatment.

The following situations are exceptions to your right to confidentiality:

1. I may use or disclose your personal healthcare information to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relative requirements of the law. Examples are public health reports, abuse and neglect reports, law enforcement reports, and reports to coroners and medical examiners in connection with investigation of deaths. I must also make disclosures to the Secretary of the Department of Health & Human Services for the purpose of investigating or determining my compliance of the requirements of the Privacy Rule.
2. I may disclose your healthcare information when necessary to minimize an imminent danger to the health and safety of you or any other individual.
3. I may use your personal healthcare information to contact you to remind you of your appointments with me.
4. I may disclose your personal healthcare information to Business Associates that are contacted by me to perform professional services on my behalf which may involve their collection, use or disclosure of your personal information. My contact with these entities requires them to safeguard the privacy of your information.
5. I may disclose your personal healthcare information if a court of competent jurisdiction issues an appropriate order. I will also disclose your personal healthcare information if: 1) you and I have each been notified in writing at least fourteen days in advance of a subpoena or other legal demand, identifying the personal healthcare information sought, and the date by which a protection order must be obtained to avoid my compliance; 2) no qualified judicial or administrative protective order

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has been obtained; 3) I have received satisfactory assurances that you received notice of an opportunity to have limited or quashed the discovery demand; and 4) such time has elapsed.

Uses & Disclosures of Your Personal Healthcare Information Made With Your Authorization:

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

Changes to this Notice of Privacy

I am required to abide by the terms of the Notice of Privacy Practices, but I am also permitted to change the terms of this Notice at any time. Once a revision is in effect, it applies to all of your personal healthcare information that I maintain whether or not you are still in treatment with me. You may request a copy of my revised Notice of Privacy Practices at any of your appointments or ask that one be mailed to you by leaving me a message on my voice mail.

Contact Information

I am my own Privacy Officer, so if you have any questions about this *Notice of Privacy Practices*, please contact me:

Alyssa Hagmann, M.A., LMFT
4041 Ruston Way Suite 202
Tacoma, WA 98402
ph: 253-254-6681
fax: 253-248-0239

Complaints

If you believe I have violated your privacy rights, you may file a complaint in writing with me. I will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of the Department of Health & Human Services through the Health Professions Quality Assurance Division at (360)236-4900 or write to the Department at P.O. Box 47869, Olympia, WA 98504.

My signature indicates that I have read and understand the information contained in this Notice of Privacy Practices, and that I enter into the therapy process agreeing to the terms and exceptions of confidentiality described herein.

Client Signature_____ Date _____

Client Signature_____ Date _____

Parent/ Guardian _____ Date _____
(if client is under 13 years old)

Therapist_____ Date _____