Community Psychological Consultants

An Association of Independent Mental Health Practitioners

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Informed Consent for Treatment

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

The Notice of Privacy Practices is required by a federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Notice of Privacy Practices provides information regarding how your medical information may be used and disclosed, as well as explaining your rights regarding that information.

The law requires that we must maintain the privacy of your health information called Protected Health Information (PHI). Protected Health Information is the information that you provide us or that we create or receive about your health care. The law also requires us to provide you with this Notice of our legal duties and privacy practices. When we use or disclose your PHI, we are required to follow the terms of this Notice at the time we use or share the PHI. The law provides you with certain rights set forth in this Notice.

Uses and Disclosures of Protected Information

Uses and Disclosures for Treatment, Payment, Health Care Operations: We may use and disclose your PHI without consent or authorization for *treatment*, *payment*, and *health care operations* purposes:

- *Treatment*: Treatment refers to the provision, coordination, or management of health care and related services by one or more health care providers. We may use and disclose your PHI to provide you with medical care treatment or services. We may use and disclose your PHI with physicians, psychiatrists, therapists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care.
- *Payment*: Payment refers to the activities undertaken by a health care provider to obtain or provide reimbursement for the provision of health care. We may use and share your PHI to bill and obtain payment for services and treatment provided. This may include the use and disclosure of your PHI with your insurance company, a third company, and/or the party responsible for your bill. The information provided to insurers or other third party payers may include identifying information, as well as your diagnosis and other information about your treatment.
- *Health Care Operations*: Health care operations refer to activities undertaken by the provider that are regular functions of management and administrative activities of the practice. We may use and disclose your PHI for activities that relate to the performance and operation of our practice. Examples of health care operations include, but are not limited to, quality assessment and improvement activities, administrative services, care management and coordination, training and educational programs, accreditation activities, and obtaining legal services.

Other Uses and Disclosures: We may use and disclose your PHI without consent or authorization under the following circumstances:

- *Abuse:* We are mandated by law to report any reasonable suspicions of a child, elderly adult, or dependent adult being abused or neglected to either the Indiana Department of Child Services or the Indiana Adult Protective Services.
- *Serious Threat to Health or Safety of Self:* If we have reason to believe that you present a serious risk of physical harm or death to yourself, we may need to use and disclose your PHI in order to protect you.
- *Serious Threat to Health of Safety of Others:* If you communicate to us an explicit threat of imminent and serious physical harm or death to an identifiable individual(s), and we believe that you may act on the threat, we have a legal duty to take the appropriate measures to prevent harm to the individual(s). This may include disclosing your PHI to the appropriate law enforcement and taking reasonable efforts to warn the individual(s).
- *Worker's Compensation:* We may use and disclose your PHI as authorized by, and to the extent necessary to comply with law relating to worker's compensation or other programs established by law, that provide benefits for work-related injuries or illness without regard to fault.
- *Health Oversight Activities:* We may use and disclose your PHI if we are required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider. Other health oversight activities can include licensure or disciplinary actions. In the event that a patient files a complaint or lawsuit against the practice or one of our providers, we may disclose relevant information regarding your PHI.
- *Judicial and Administration Proceedings:* If you are involved in a court proceeding and a request is made for information by any party about your treatment and the subsequent records, it is not to be released without a court order. Information about other services (e.g., psychological evaluation) is also privileged and will not be released without your authorization or a court order. The privilege does not apply when you are being evaluated on behalf of a third party or the evaluation and/or treatment is court ordered.
- *National Security:* We may use and disclose your PHI to authorized federal officials required by lawful intelligence, counterintelligence, and other national security activities. We may be required by law to use and disclose your PHI to a correctional institution or law enforcement official having lawful custody of your PHI under certain circumstances.
- *Emergencies*: We may use and disclose your PHI in the event of a life-threatening emergency.
- *Crimes*: Crimes that are observed by the provider or the provider's staff, crimes that are directed toward the provider or the provider's staff, or crimes that occur on the premises of the office may be reported to law enforcement.
- *Patient Contact*: We may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.
- *Research*: Under certain limited circumstances, we may use and disclose your PHI for research purposes. Your authorization will be secured for these uses and disclosures of your PHI.
- *As required by law:* We may use and disclose your PHI when required to do so by any other law not already referred to above.

Rights Regarding Your Protected Health Information

Right to Inspect and Copy Your Health Information: You may provide a written request for access to your PHI and/or copies of your PHI. Access to your PHI may be limited or denied under certain circumstances. You have a right to request a review of that decision.

Right to Receive Confidential Communications: You may provide a written request if you would like your PHI to be sent to a different location than the address that you provided or by an alternate method. We are obliged to agree to your request providing that we can provide you the PHI in the format you requested, without undue inconvenience.

Right to Request Restrictions: You may request that we limit the way we use and disclose your PHI. You have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. While we will consider your request, we are not legally bound to agree. If we do agree to your request, we will require a written request and agree to comply with the request except in emergency situations.

Right to Amend Your Records: You have the right to request in writing an amendment of your PHI for as long as your PHI records are maintained. The request must identify the information that you are wanting amended and include an explanation of why you think it should be amended. If the request is denied, a written explanation explaining the reason(s) for the denial will be provided. If the request is approved, we will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your PHI will be deleted.

Right to Receive an Accounting of Disclosures: You may ask for an accounting of certain disclosures of your PHI made by us on or after August 1, 2019. These disclosures must have occurred before the time of your request, and we will not go back more than six (6) years before the date of your request. If you request an accounting more than once during a twelve (12) month period, you may be charged.

For Further Information or to Report Complaints: If you want more information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we have made about access to your PHI, we encourage you to contact us at any time. You may also file a written complaint to the Indiana Professional Licensing Agency or the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Right to Receive Paper Copy of this Notice: You have a right to obtain a paper copy of this notice.

Electronic Communication/Consent to Use Telehealth Services

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the videoconferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. To maintain confidentiality, I will not share my telehealth appointment link with

anyone unauthorized to attend the appointment and I will ensure that I am in a physical locationthat ensures my privacy and confidentiality.

By signing this form, I acknowledge that:

I have read or had this form read and/or explained to me

1. I fully understand its contents including the risks and benefits of the procedure(s).
2. I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices from Community Psychological Consultants.

_____	_____
Patient Name	Patient/Parent/Legal Guardian Signature
_____	_____
Date	Printed Name of Parent/Legal Guardian (if applicable)

Effective Date and Changes to Privacy Practices

Effective Date: This Notice is effective as of February 10, 2021. Please note that we reserve the right to change the terms of this Notice and our privacy practices at any time as permitted by law. Any changes to this Notice and our privacy practices will be posted in our office. Please note that you may request a copy of this Notice at any time.

FOR PROVIDER USE ONLY

The Notice of Privacy Practices was presented to the patient or parent/legal guardian of the patient, but the patient or parent/legal guardian of the patient did not sign the acknowledgement due to the following reason:

- Refusal to sign
- Incapable of signing
- Other _____

_____	_____
Signature of Provider	Date