Stillwell
COUNSELING SERVICES
Individual and Family Counseling

Notice of Privacy Practices

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

Uses and Disclosures
I may use or disclose your protected health information (PHI), for treatment, payment and health care operations purposes with your consent.

Treatment Your health information may be used or disclosed when I consult with another health care provider such as your family physician or another professional.

Payment Your health information may be used to determine eligibility and coverage and to seek payment from your health plan or other sources of coverage that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the condition being treated.

Health care operations Your health information may be used as necessary to support the day-to-day activities and management of my practice**.** For example, information on the services you received may be used to support quality assessment and improvement activities, business-related maters such as audits and administrative services and case management and care coordination.

Other uses and disclosures require your authorization
Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

***Child Abuse -** If I have reason to suspect that a child has been injured as a result of physical, mental or emotional abuse or neglect or sexual abuse, I must report the matter to the appropriate authorities as required by law.
***Adult & Domestic Abuse** If I have reasonable cause to believe that an adult is being or has been abused, neglected or exploited or is in need of protective services, I must report this belief to the appropriate authorities as required by law.
***Health Oversight Activities** I may disclosed PHI to the Kansas Behavioral Sciences Regulatory Board if necessary for a proceeding before the Board.
***Judicial & Administrative Proceedings** If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

***Serious Threat to Health or Safety –** If I believe that there is a substantial likelihood that you have threatened an indentifiable person and that you are likely to act on that threat in the foreseeable future, I may disclose information in order to protect that individual. If I believe that you present an imminent risk of serious physical harm or death to yourself, I may disclose information in order to initiate hospitalization or to family members or others who might be able to protect you.
***Workers Compensation –** I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Professional's Duties
I am required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. I am also required to abide by the privacy policies and practices that are outlined in this notice
.

Right to Revise Privacy Practices
As permitted by law, I reserve the right to amend or modify my privacy policies and practices. These changes in my policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, I will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that I maintain.

Requests to Inspect Protected Health Information
As permitted by federal regulation, I require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting me.

Complaints
If you would like to submit a comment or complaint about my privacy practices or if you believe that your privacy rights have been violated, you should call the matter to my attention by sending a letter describing the cause of your concern to:

Stillwell Counseling Services
1611 7th Street Clay Center, KS 67432

You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date
This Notice is effective on or after August 1, 2018

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We Care About Your Privacy

The privacy of your medical information is important to me. I understand that your medical information is personal and I am committed to protecting it. I create a record of the care and services you receive here. I need this record to provide you with quality care and to comply with certain legal requirements. The attached notice will tell you about the ways I may use and share medical information about you. The notice describes your rights and certain duties that I have regarding the use and disclosure of medical information.

Please sign below and return this form to me or my receptionist acknowledging that I have provided you with the attached "Notice of Privacy Practices". If you have questions about this notice, please discuss your concerns with me.

Tina Stillwell, LSCSW _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the "Notice of Privacy Practices" on _____
(Date)

_____ _____
Name of Patient (Print or Type) **Signature of Patient**

_____ _____
Signature of Patient Representative **Relationship to Patient**
(Required if patient is a minor or an adult who is unable to sign this form.)

For Office Use Only:

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices. The acknowledgement was not obtained because:

☐ **The patient declined to sign the acknowledgement**

☐ **Other** _____

_____ _____ _____
Name of Patient **Name of Staff Member** **Date**