THE HEIGHTS
COUNSELING AND WELLNESS

NOTICE OF PRIVACY PRACTICES

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

As a client of The Heights Counseling and Wellness, LLC., you are entitled to receive notice about our privacy practices and how we may use and disclose protected health information (PHI) about you in different circumstances. This Notice explains how we may use and disclose your PHI, the choices and rights you have about how your PHI may be used and disclosed, and our obligations to protect the privacy of your PHI.

Introduction. When you become a client of The Heights Counseling and Wellness, LLC., you provide us with information about your health. Each time you visit or contact us, another record is made. Your health record is the information that we use to plan your care, provide treatment and receive payment for our services. It is important for you to understand that your health record contains health information that is protected by federal and state laws.

Our Responsibilities. The Heights Counseling and Wellness, LLC., is required to maintain the privacy of your PHI and to provide you with a notice about our legal duties and privacy practices with respect to your PHI. We are required to follow the terms of the notice currently in effect. We reserve the right to change the terms of our privacy practices at any time. The new notice will be effective for all protected health information that we maintain at that time. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to all clients with open accounts (balances owing or continuing in treatment). Our current notice will always be posted on our website, **TheHeightsWellness.com**.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- "*Use*" applies only to activities within our offices such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our offices such as releasing, transferring, or providing access to information about you to other parties.

• *"Treatment, Payment and Health Care Operations"*

– *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
– *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
– *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose your PHI without your written consent or authorization in the following limited circumstances:

Required by Law: We may disclose your PHI as required by law, but this information will be limited to the relevant requirements of the law and you will be notified, when required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI to a public health authority for the purposes of controlling disease, injury, or disability. For example, we may make a report regarding a communicable disease.

Child Abuse: If we have reason to believe that a child has been subjected to incest, molestation, sexual exploitation, sexual abuse, physical abuse, or neglect, or we observe a child being subjected to conditions or circumstances which would reasonably result in sexual abuse, physical abuse, or neglect, we must immediately notify the nearest peace officer, law enforcement agency, or the DC Division of Child and Family Services.

Adult and Domestic Abuse: If we have reason to believe that a vulnerable adult is suffering from abuse, neglect, abandonment, exploitation, or domestic violence we are required by law to make a report to Protective Services intake, or the nearest law enforcement agency as soon as we become aware of the situation.

Judicial or administrative proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that we have provided you or your records, such information is privileged under state law, and we must not release this information without written authorization from you or your personal or legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered.

Serious Threat to Health or Safety: If you communicate to us an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable person, and you have the apparent intent and ability to carry out that threat, we have the legal duty to take reasonable precautions. These precautions may include disclosing relevant information from your mental health records which is essential to protect the rights and safety of others. We also have such a duty if you have a history of physical violence of which we are aware and

we have reason to believe there is a clear and imminent danger that you will attempt to kill or inflict serious bodily injury upon a reasonably identifiable person.

Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations and the limited situations described above only when your written authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. Appropriate forms are available from the clinician.

Client's Rights and Mental Health Service Provider's Duties

You have the right to do the following:

Right to Request Additional Restrictions on Uses and Disclosures of Your Health Information- You have the right to request that we place additional restrictions on how we use or disclose your PHI. While we will consider any request for additional restrictions, we are not required to agree to your request. If we do agree with your request we will not violate the restriction unless it is needed to provide emergency treatment.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are a client. Upon your request, we will send your bills to another address. We must accommodate your request if it is
reasonable, specifies the alternative means or location, and continues to permit us to receive payment for services.

Right to Amend Your Health Information – You have the right to request in writing that we amend health information maintained in your health record. We will comply with your request in the event that we determine the information that would be amended is false, inaccurate or misleading.

Right to Receive an Accounting – You have the right to receive an accounting of certain disclosures made by us of your PHI.

Right to a Receive a Paper Copy – You have the right to receive a paper copy of this notice upon request, even if you have agreed to receive the notice electronically. You may obtain a copy from your clinician.

Right to Receive Further Information – You have the right to discuss with your clinician if you want additional information about our privacy practices, your privacy rights, or disagree about a decision made about your PHI, or if you believe that your privacy rights have been violated.

Right to File a Complaint– If you believe your privacy rights have been violated, in addition to filing a complaint with us, you have the right to file a written complaint with the Office of Civil Rights of the United States Department of Health and Human Services. Under no circumstances will we retaliate against you for filing a complaint with us or the Office of Civil

Rights. We support your right to the privacy of your PHI .

Safeguards and E-mail: We have created appropriate physical, technical, and administrative safeguards to protect the confidentiality of your PHI. Currently e-mail communications between you and us are not encrypted and we cannot guarantee that others would not intercept such communications. Therefore, we encourage you to continue to communicate with us by telephone or regular mail. If you do request that we e-mail you certain information, we will treat your request as representing your consent for us to respond via e-mail with communications that may include PHI. We would take care to ensure that any PHI communicated would be within the body of the e-mail and not within the subject line.

Effective Date of this Notice. This Notice is effective as of 8/24/18

NOTICE OF PRIVACY PRACTICES:
ACKNOWLEDGMENT OF RECEIPT

By my signature below I acknowledge receipt of the Notice of Privacy Practices from The Heights Counseling and Wellness, LLC.

Client's full name (please print)	Client's signature
Client's birthdate	Date

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THIS PORTION TO BE COMPLETED WHEN A CLIENT IS UNABLE TO GIVE WRITTEN ACKNOWLEDGEMENT

We, the undersigned, do verify that the Notice of Privacy Practices has been received by the client and/or client's parent/legal guardian if client is a minor and/or client's personal representative.

Client's full name (please print)	Printed name of person signing on behalf of client
Client's birthdate	Signature of person signing on behalf of client
Date of signature	Relationship to client (parent, legal guardian, personal representative)