NOTICE OF PRIVACY PRACTICES

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

PLEASE READ IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be a referral to another Physician.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this Would be sending a bill to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

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

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it or the information is needed to provide you with emergency treatment.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. A request must be made in writing to this office.

- The right to inspect and copy your protected health information; however, "Psychotherapy notes" are singled out for specific protection from disclosure under HIPAA (164.524(a)(1)(l). A fee will be charged for all copied records.

- The right to amend your protected health information. If you believe that medical information used to make decisions about your care is incorrect or incomplete, you may ask us to amend the information. You must have a valid reason for the amendment of your psychotherapy notes.

- The right to receive an accounting of disclosures of protected health information for the previous six years, beginning April 14, 2003. You are not entitled to an accounting of disclosures made for purposes of treatment, payment, or healthcare operations.

- The right to obtain a paper copy of this notice from us upon request.

All requests must be in writing to this office addressed to the privacy officer. We will review all requests and give written notice within 60 days as to our decision. If you disagree with our decision, you may submit a request for review of the decision to the privacy officer who will get a third party to review the decision.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint at the addresses below regarding violation of the provisions of this notice or the polices and procedures of our office.

For more information about HIPAA or to file a complaint contact:

U.S. Department of Health and
Human Services Office of Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll free: 1-877-696-6775

Privacy Officer
Diane Farrington Curtis, MA, LPC
2202 S. Ong
Amarillo, TX 79109
(806)220-5466

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple Healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand your Notice of Privacy Practices containing more complete descriptions of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Insurance
All insurance companies require information regarding diagnosis, treatment dates, and type of treatment. Some require more extensive information such as current symptoms and prior treatment and/or personal background.

Canceled Appointments
Since your appointment time is reserved just for you, I bill $50.00 for missed appointments not canceled at least 24 hours in advance (except in emergencies). Fees for missed sessions are not covered by insurance. Out of respect for all patients, three missed appointments (except due to an emergency) may result in my not scheduling any further appointments due to the number of patients waiting for an opening.

Payment
I ask for payment at the time services are provided. If billing insurance, you will be responsible for any copay or deductible amounts at the time of your visit. If your insurance changes in any way (different policy number, insurance company, etc.), I ask that you notify me at least 2 days before your scheduled appointment. If you do not have your insurance information at the time of your appointment, you will be responsible for the entire charge for that appointment.

If your financial situation changes or if you consider discontinuing sessions due to finances, please discuss your concerns with me. Different arrangements can sometimes be made. There will be a $25 charge for all returned checks.

Office Hours/Emergencies
Should you need to reach me between appointments, please call or text (806)220-5466. Your call will be returned as soon as possible. I bill for frequent or lengthy non-emergency calls. In the evenings and on weekends messages may be left on my voicemail. Calls will be returned during the following business day. In emergency situations contact or present to Northwest Texas Hospital Emergency Receiving Center at (806) 354-1000, 1501 S. Coulter.

If you have any questions about these policies, please ask. I look forward to working with you.

I have read, understand, and agree to the above stated policies.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____