***Jennifer Bonness, LMHC, LLC***

***All About You Counseling Center***

*1881 NE 26th Street, Suite 102, Wilton Manors, FL 33305*

*Phone: 954-601-4402 Email:* *JenniferBonnessLMHC@gmail.com*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Effective Date: 10/1/2014**

**HIPAA 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 REVIEW THIS NOTICE CAREFULLY.**

Your health record contains personal information about you and your health. This is information about you that relates to your past, present, or future physical or mental health, condition, related health care services, and may identify you. This information is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclosed your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations stipulated under HIPAA including the HIPAA Privacy and Security Rules, and the *American Mental Health Counselors Association (AMHCA)*. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

**Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent**. I may use and disclose your PHI without your consent for the following reasons:

**For Treatment.** Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. I may disclosed your PHI to other therapists, physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services and are otherwise involved in your medical care.

**For Payment.** I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. For example, I may provide your health plan information about you so that the insurance company will pay for your treatment. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations.** I may use or disclose, as needed, your PHI in order to support my business activities including but not limited to quality assessment activities, licensing, and conducting or arranging other business activities. For example, I may share your PHI with third parties that perform various business activities, such as billing or typing services, provided we have a written contract with the business that requires it to safeguard your privacy of your PHI. For training or teaching purposes, PHI will be disclosed only with your authorization. I may disclosed your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I may use your PHI in the evaluation of the quality of health care services that you received. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

**Appointment Reminders.** I may use and disclose your PHI to contact you to remind you of a future scheduled appointment.

**Email Communication**. With your expressed and written permission, I may use and disclose PHI to communicate with you via email regarding appointments, general communication, or related to your treatment.

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, I may share PHI with a person who is involved in your medical care or payment for your care, such as a family or close friend. I also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**Business Associates.** I may have Business Associates, such as billing services, bookkeepers, accountants, etcetera, who may have access to your PHI when they are preparing routine financial statements, or entering any payments from your, or insurance companies.

**SPECIAL SITUATIONS**

**As Required by Law.** I will disclose PHI when required to do so by international, federal, state, or local law.

**The following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of situations. These disclosures do not require prior written consent or authorization by you.**

**Abuse or Neglect.** If I have reasonable suspicion to believe that any minor (under the age of 18 years old) has been the victim of abuse, neglect, or exposure to violence, I am legally responsible to report and disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

If I have reason to believe that abandonment, abuse, financial exploitation or neglect of a vulnerable disabled adult has occurred, I am legally responsible to report and disclose your PHI to a state or local agency that is authorized by law to receive reports of elder abuse or neglect.

**To Avert a Serious Threat to Health or Safety.** I may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to your health or safety and safety or the health and safety of the public or another person. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Coroners, Medical Examiners and Funeral Directors.** I may release PHI to a coroner or medical examiner. This may be necessary, for instance, to identify a deceased person or determine the cause of death. I also may release PHI to funeral directors as necessary for their duties.

**Data Breach Notification Purposes.** I may use or disclose your protected PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

**Deceased Patients.** I may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

**Duty to Warn.** If I have a reason to believe that there is an imminent danger to the health or safety of the client or any other individual, I may be legally required to take protective action(s). These actions may include notifying the potential victim, contacting the police, seeking hospitalization for the client, or contacting family members or others who can help provide protection.

**Health Oversight Activities.** If required, I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings, Lawsuits and Disputes**. I may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order, or similar process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. If you are involved in a lawsuit or dispute, I may disclose PHI in response to a court or administrative order.

**Law Enforcement.** I may disclose PHI to a law enforcement official as required by law if the information is: (1) in compliance with a subpoena (with your written consent), warrant, summons, court order, administrative order or similar document; (2) limited information for the purpose of identifying a result of suspect, material witness, fugitive, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, I am unable to obtain the person’s agreement; (4) in connection with a deceased person I believe may be the result of criminal conduct; (5) in connection with the reporting of a crime in an emergency, the location of the crime or victims, or the identity, description, or location of the person who committed the crime; or (6) about criminal conduct on the premises of my business.

**Medical Emergencies.** I may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. I will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

**National Security and Intelligence Activities.** I may release PHI to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

**Protective Services for the President and Others.** I may disclose PHI to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or to conduct special investigations.

**Public Health Risks.** If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, report births and deaths, report reactions to medications or problems with products, notify people of recalls of products they may be using, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

**Specialized Government Functions**. I may review requests from U.S. military command authorities if you have served as a member of the armed forces, or are a current member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm. I also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

**Workers' Compensation**. I may release PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

**With Authorization.** Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that I have already made a use or disclosure based on your information. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

**YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR ALL OTHER USES AND DISCLOSURES.**

**USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT:**

**Individuals Involved in Your Care or Payment for Your Care.** Unless you object, I may disclose to a member of your family, a relative, a close friend, or any other person you identify, your PHI that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, I may disclose such information as necessary if I determine that it is in your best interest based on my professional judgment.

**Disaster Relief.** I may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. I will provide you with an opportunity to agree or object to such a disclosure whenever I practically can do so.

**YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding PHI that I maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer indicated at the end of this notice.

* **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records, and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. If I do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and I will comply with the outcome of the review. I may charge a reasonable, cost-based fee for copies. I may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefits program. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person. I have up to 30 days to make your PHI available to you.
* **Breach Notification.** If there is a reach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
* **Right to Amend**. If you feel that the PHI I have about you is incorrect or incomplete, you may ask to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer, **Jennifer Bonness, LMHC,** if you have any questions.
* **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures that I make of your PHI for purposes other than treatment, payment and health care operations or for which you provided written authorization. I may charge you a reasonable fee if you request more than one accounting in any 12 month period. To request an accounting of disclosures, you must make your request, in writing, to **Jennifer Bonness, LMHC.**
* **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. You also have the right to request a limit on the PHI I disclose to someone involved in your care or the payment for your care, such as a family member or friend.

To request a restriction, you must make your request, in writing, to **Jennifer Bonness, LMHC**. I am not required to agree to your request unless you are asking me to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If I agree, I will comply with your request unless the information is needed to provide you with emergency treatment.

* **Out-of-Pocket-Payments**. If you paid out-of-pocket, such as you have requested that I do not bill your health plan, in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and I will honor that request.
* **Right to Request Confidential Communication.** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as condition for accommodating your request. I will not ask you for an explanation of why you are making the request. To request confidential communications, you must make your request, in writing, to **Jennifer Bonness, LMHC**. Your request must specify how or where you wish to be contacted. I will accommodate reasonable requests.
* **Right to a Copy of this Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, inquire with **Jennifer Bonness, LMHC.**

**CHANGES TO THIS NOTICE**

I reserve the right to change this notice and make the new notice apply to PHI I already have as well as any information I receive in the future. I will post a copy of my current notice at my office. The notice will contain the effective date on the first page, in the top right-hand corner.

**COMPLAINTS**

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with **Jennifer Bonness, LMHC**, at 1881 NE 26th Street, Suite 102, Wilton Manors, FL 33305 / 954-601-4402, or with the Secretary of Health and Human Services at 200 Independence Avenue, S. W., Washington, D.C. 20201, or by calling 202-619-0257. **I will not retaliate against you for filing a complaint.**

**The effective date of this Notice is October 1, 2014.**

***Jennifer Bonness, LMHC***

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**Acknowledgement of Receipt of HIPAA Notice of Privacy Practices**

The undersigned acknowledges receipt of a copy of the currently effective HIPAA Notice of Privacy Practices. A copy of this signed and dated acknowledgment shall be effective as the original.

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**Signature of Client (or Legal Guardian if client under 18)**

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**Printed Name of Client (or Legal Guardian if client is under 18 and indicate relationship to client)**

If you have any questions about this form, or the attached notice, please contact:

**Jennifer Bonness, LMHC**. Thank you.