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NOTICE OF PRIVACY PRACTICES
HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA)
CLIENT RIGHTS AND THERAPIST DUTIES DOCUMENT

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I, J. Olivia Drumm, LCPC, provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with the HIPAA Notice. If you have any questions, it is your right and obligation to ask, so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary.

Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment. Such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.

2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.

3. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

4. If a client files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the client's employer, the insurance carrier or an authorized qualified rehabilitation provider.

5. I may disclose the minimum necessary health information to my business associates that perform functions on my behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the appropriate government agency such as the Department of Public Health and Human Services. Once such a report is filed, I may be required to provide additional information.

2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the appropriate government agency such as the Department of Public Health and Human Services. Once such a report is filed, I may be required to provide additional information.

3. If I believe that there is a clear and immediate probability of physical harm to the client/patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victims, and/or appropriate family member, and/or the police, or appropriate government agency to seek hospitalization of the client.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

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. This includes consultation with clinical supervisors, or other treatment team members, as well as family members and friends involved in your treatment with your verbal permission, and colleagues or peers in psychology and the behavioral health field. I may disclose PHI to any other consultant only with your authorization.

For Payment. I may use or disclose PHI so that we can receive payment for the treatment services provide d to you. This will only be done with your authorization. Examples of payment related activities include: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

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, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging

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for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI.

For Training or Teaching Purposes. PHI will be disclosed only with your authorization.

Required by Law. Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

RIGHTS OF THE PATIENT

- *Right to be treated* with dignity and respect.
- *Right to ethical treatment* without discrimination, regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- *Right to be involved* in the planning and/or revision of your treatment plan.
- *Right to know* about your treatment progress or lack thereof.
- *Right to reject the use of any therapeutic technique*, and to ask questions at any time about the methods used.
- *Right to be spoken to* in a language that is fully understood.
- *Right to a clean and safe* environment.
- *Right to refuse to be video-taped*, audio recorded, or photographed.
- *Right to end treatment* at any time.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by my office. To exercise any of these rights, please submit your request in writing to J. Olivia Drumm, LCPC at PO Box 1114, Helena, MT 59624.

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 may be used to make decisions about your care. This right will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information, although I am not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures that I make of your PHI.

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. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.

Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.

Breach Notification. If there is a breach of unsecured protected health information 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 a Copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 2021, or by calling (202) 619-0257. I will not retaliate against you for filing a complaint.

DUTIES OF THE THERAPIST

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA) CLIENT RIGHTS AND THERAPIST DUTIES DOCUMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE REVIEWED THE HIPAA NOTICE FORM ABOVE AND A COPY HAS BEEN MADE AVAILABLE TO YOU, THE CLIENT/PATIENT.

Client 1 Printed Name and Signature Date

Client 2 or Parent/Guardian Printed Name and Signature Date

J. Olivia Drumm, LCPC Date