PATRICK SCHULTZ LLC

NOTICE OF PROVIDER 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 IT CAREFULLY.

In general, when we release your health information, we must release only the information we need to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We reserve the right to change the privacy practices described in this notice, in accordance with the law. If we change our privacy practices, you will receive a revised copy.

Without your authorization, we can use your health information for the following purposes:

1. **Treatment.** A Therapist may use the information in your record to determine which treatment option might be best for you. This will be documented in your record, so that other professionals can help you in the future if needed.

2. **Payment.** In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the treatment provided to you. As a result, we will pass such health information onto an insurer in order to help receive payment for your medical bills.

3. **Health Care Operations**. We may need your diagnosis, treatment, and outcome information in order to improve the quality or cost of care we deliver.

4. **As required or permitted by law**. Sometimes we must report your health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we have to report suspected child abuse or neglect, elder abuse or neglect, or to respond to a court order or subpoena.

5. **For health oversight activities**. We may disclose your information to authorities so they can monitor, investigate, inspect, discipline or license those who work in our facility.

6. **To avoid a serious threat to health or safety**. As required by law and standards of ethical conduct, we may release your information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize physical harm to yourself or others.

7. **For military, national security, or incarceration/law enforcement custody**. If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your health information to the proper authorities so they may carry out their duties under the law.

8. **To those involved with your care or payment of your care**. If people such as family members are helping care for you or helping you pay your counseling bills, we may release important health information about you to those people. The information released to these people may include services provided and your general condition. **You have the right to object to such disclosure**.

NOTE: Except for the situations listed above, we must obtain your specific written authorization for any other release of your health information.

If you sign an authorization form, you may withdraw your authorization at any time, as long as your withdrawal is in writing.

Your Health Information Rights

You have several rights with regard to your health information. You have the right to:

1. **Inspect and copy your health information**. With a few exceptions, you have the right to inspect and obtain a copy of your information. In addition, we will charge you a reasonable fee if you want a copy of your health information. The current fee is 25 cents per page. You may view your records with staff present.

2. **Request to correct your health information**. If you believe your documentation is incorrect, you may ask us to correct the information. You will be asked to make such requests in writing and to give a reason as to why your information should be changed. However, if we did not create the information that you believe is incorrect, or if we disagree with you we may deny your request.

3. **Request restrictions on certain uses and disclosures**. You have the right to ask for restrictions on how your counseling information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or health care operation activities. However, we are not required to agree in all circumstances to your requested restriction.

4. **As applicable, receive confidential communication of health information**. You have the right to ask that we communicate to you in different ways or places.

5. **Receive a record of disclosures of your health information**. In some instances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years, but the request cannot include dates before April 14, 2003. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. We must comply with your request for a list within 60 days, unless you agree to a 30-day extension, and we may not charge you for the list, unless you request such list more than once per year. In addition, we will not include in the list disclosures made to you, or for purposes of treatment, payment, health care operations, national security, law enforcement/corrections, and certain health oversight activities.

6. **Complain**. If you believe your privacy rights have been violated, you may file a complaint with us and with the federal Department of Health and Human Services. We will not retaliate against you for filing such a complaint. To file a complaint with either entity, please contact Patrick Schultz who will provide you with the necessary assistance and paperwork.

Again, if you have any questions or concerns regarding your privacy rights or the information in this notice, please contact Patrick Schultz.

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

For office use only:

Client Name:_____
Record #:_____
Date of Admission:_____

By signing this form, you acknowledge that Patrick Schultz LLC has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

[ ] **I received Patrick Schultz LLC Privacy Notice**

[ ] **Patrick Schultz LLC has given me the chance to discuss my concerns and questions about the privacy of my health information.**

_____

Patient's Signature Date

Patrick Schultz LLC staff should complete if Acknowledgement Form is not signed:

1. Does patient have a copy of the Privacy Notice?

   [ ] Yes [ ] No

2. Please explain why the patient was unable to sign an acknowledgement form and our efforts in trying to obtain the patient's signature:

_____
_____
_____