Trish J. Nauss, LCSW-R

A Different View Psychotherapy LCSW PLLC
Individual & Couples Therapy

Notice of Privacy Practices

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS & DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Various Federal and New York State Laws and Regulations and the Ethics Standards for Clinical Social Workers require that clinical social workers protect the privacy & confidentiality of their client's health information (including mental health). As a clinical social worker I take this legal & ethical obligation very seriously. The federal Health Insurance Portability and Accountability Act ("HIPAA"), requires that clients are provided with a notice of privacy practices that I follow in my practice in regards to the protection of the privacy and confidentiality of their health information or what HIPAA refers to as "Protected Health Information" or "PHI". I am required to follow these practices as described in this notice. However, I may amend these practices from time to time as long as they continue to comply with applicable Federal and New York State Laws and regulations.

Confidentiality

As a rule, I do not disclose information about you, including the fact that you are my client, without your written consent. My records, both electronic and written, describe your personal information, services provided to you, dates of sessions, diagnosis, functional status, symptoms, prognosis, and progress, as well as all forms you sign. Health care providers are legally allowed to share this information for treatment, payment and healthcare operations purposes. However, I do not typically disclose this information, so in such cases I will request your written permission in advance, either through your consent at the onset of our working relationship or any time during your treatment (by signing the Consent for Release of PHI form), or through your written authorization at which time the need for disclosure arises. You have the right to revoke your permission, in writing, at any time, by contacting me.

"Limits of Confidentiality"

Possible Use and Disclosures of Mental Health Records without Consent or Authorization:

The following are some of the important exceptions to this confidentiality rule, some of which are required by law and some created of my own choice for additional protection. In order for you to receive Mental Health services from me, you must sign this form indicating that you understand and accept my policies regarding confidentiality and its limits. We will discuss these together now, but please know that at any time during our work together you may reopen a conversation about them.

Here are some situations in which I will disclose records or information, "PHI", about you without your consent or authorization, either by my own policy or as required by Law:

Child Abuse-I am required by New York State law to report any suspicion I may have that a child is being abused or neglected to the Department of Social Services. The report will be made immediately and relevant information will be provided.

Adult/Elderly Abuse-I am required by New York State law to report any suspicion I may have that an adult, elderly person or incapacitated adult is being abused, exploited or neglected to the Department of Social Services. The report will be made immediately and relevant information will be provided.

Serious Threat to Safety or Health-As a Licensed Clinical Social Worker, I am required by New York State law to report any communication you may make to me that would indicate your specific and immediate intention to cause serious bodily injury, harm or death, to either an identified or unidentified person, and I believe you have the ability to carry out this threat immediately or imminently. I am legally required to take steps to protect third parties in such situations. These steps may include: warning potential victims or the parent/guardian of a potential victim if under 18, notifying a law enforcement officer, or seeking your hospitalization. Additionally, my own policy may include use and disclosure of your PHI if and when I feel it is necessary to prevent any immediate or serious threat to your own health and safety.

Court Proceedings-If you are involved in legal issues and court proceedings and as a result I receive a request by the courts for your information including diagnosis, treatment, and records, etc., please know that such information is privileged under New York State law, and I will not release this information without your written consent or authorization unless a judge issues a court order for the release of such information, at which time I would be legally obligated. Additionally, if I receive a subpoena for records or testimony, I will notify you so that you can file a motion to block the subpoena.

Worker's Compensation-Upon request, I am required by law to submit relevant information about your mental health to you, your employer, the insurer, or a certified rehabilitation provider should you file a worker's compensation claim.

Personal/Other Emergency-In the case that you are involved in a serious and/or life threatening emergency situation and I am unable to ask for your permission, I will use or disclose your information, PHI, if I believe you would have wanted me to do so or if I believe it would benefit you or your situation in the case of your safety or health.

Payments for services-Please be aware that although I make every effort to use HIPAA compliant electronic credit card processing formats, credit card processing companies have their own protection and there are always inherent limitations and risks to all electronic communications beyond reasonable control and prevention.

Telehealth Sessions- Please be aware that although I make every effort to use HIPAA compliant telehealth platforms, there are always imminent, uncontrollable & unforeseeable risks that may occur when using such formats.

Any other use or disclosure of your information, PHI, not covered in this notice or by the laws that apply to me will be made only with your written consent.

Client/Patient Rights and Provider Duties:

Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information (PHI) about you for treatment, payment and healthcare operations. You also have the right to request limits on the information that I disclose about you to someone who is involved in your care or payment of your care. You may request that I disclose information about you to another party and you may also request limits to the information that I disclose. However, please understand I am not required to agree to these restrictions. If you wish to request a restriction, you must make it in writing and include: the information you wish to be limited, whether you wish me to limit my use, disclosure or both, and to whom these limits are to apply to.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations-You have the right to request & receive confidential communications about your PHI by alternative means and at alternative locations. This means that you may request that I contact you only at certain numbers, or that I do not leave voicemails on certain numbers, or that I mail written information/bills to a specific address, etc. Upon your request I will abide by such means.

To request an alternative communication, you must make your request in writing and specify how or where you wish to be contacted. Please refer to the Communications Preferences Form as part of this Intake Packet where you can select your preferences for communication at this time and understand that at any time you may request a change through a written request as described above.

Right to an Accounting of Disclosure-You have the right to receive an accounting of disclosures of PHI for which you have not provided your consent or authorization. To request an accounting of disclosures, you must provide me with a written request.

Right to Inspect and Copy-In most cases, you have the right to inspect and copy your medical and billing records. This request must be made in writing. Please keep in mind if you request a copy of your information, I may charge you a fee for copying and mailing the information to you. Please also understand that in certain circumstances I may deny your request to inspect and copy. Also, understand I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in: a civil, criminal, or administrative proceeding.

Right to Amend-You have the right to request that your information, PHI, is corrected in the case that you feel any information I have about you is incorrect or incomplete. To request that I make such an amendment, you must put it in writing, including specific information you feel is incorrect or incomplete, as well as the reasons supporting your request. Please understand that I may deny your request in such situations that the information you request to be amended: 1-was not created by me, in which case I will add your request to that information record; 2-is not part of the information that is kept by me; 3-is not part of the information in which you would be permitted to inspect and copy; 4-is in fact accurate and complete.

Right to A Copy of this Notice-You have the right to obtain a paper copy of this notice. You may ask me to give you a copy of this notice at any time. In regards to changes to this notice, please understand: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for the information, PHI, I already have about you, as well as any information I receive in the future. In such cases, the notice will contain the effective date, a new copy will be provided to you or posted in the waiting room of this office and I will have copies of the current/updated notice available upon request.

Complaints-If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a complaint to the U.S. Department of Health and Human Services.

Client Acknowledgment of Receipt of Notice of Privacy Practices; **Please sign, print your name, and date this acknowledgement form.**

I have been provided a copy of the Notice of Privacy Practices of (Patricia)Trish J. Nauss, LCSW-R of A Different View Psychotherapy LCSW PLLC. We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I understand, and consent to accept these policies as a condition of receiving mental health services.

Printed Name:_____
Signature:_____
Date:_____

Witness: (Patricia)Trish J. Nauss, LCSW-R
Witness Signature:_____
Date:_____