DiVittore Psychology and Consulting, PLLC

NOTICE OF PRIVACY PRACTICES & HIPAA AGREEMENT

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your therapist is legally required to inform you of how your Personal Health Information (PHI) may be used or disclosed to carry out treatment, payment, or health care options and for other purposes permitted or required by law. This notice also describes your rights to access and control your PHI. PHI is data including demographic information that may identify you and relates to your past, present, or future physical or mental health/condition and related healthcare services. This disclosure should be carefully reviewed and saved. Upon request, you have the right to obtain additional paper copies of this notice from your therapist.

If you have any questions about this Notice or would like further information, please contact Dr. Krista DiVittore.

LIMITS OF CONFIDENTIALITY

Except in the following circumstances, all information you disclose to your therapist is kept confidential and not shared with anyone outside of the practice. With numbers 1-4 below, mental health professionals are required by law to break confidentiality in order to protect you and/or others who might be in danger.

1. There is reasonable suspicion of child, dependent adult or elder adult abuse or neglect. Examples include but are not limited to: sexual abuse, any physical contact that leaves bruises or scars, driving or caring for a child/dependent adult while under the influence of drugs or alcohol, child witnessing domestic violence, and providing illicit drugs or alcohol to a child or adolescent.
2. You reveal to your therapist that an alleged perpetrator (sexually, physically and/or emotionally abusive) is in contact with minors and there is reasonable suspicion he/she may still be abusing minors.
3. There is reasonable suspicion you may present an imminent danger of violence to others.
4. There is reasonable suspicion you are likely to physically harm yourself (seriously injure or attempt suicide) in the near future unless protective measures are taken.
5. You currently or have previously received relevant treatment from another healthcare provider, and have signed a Release of Information form so your therapist may consult with this provider. This will help better coordinate your treatment. While it is your decision whether to provide this consent, in some cases (i.e. – eating disorders or substance abuse), your therapist may not be able to treat you without such consent. In such cases, your therapist will need to terminate treatment and provide referrals to other providers.
6. With a completed and signed Release of Information form, your therapist can reveal all or portions of your records to any person or entity you specify. In advance of any disclosure, you have the right to inspect/know any records/information to be given to such persons or entities. Your therapist will inform you whether or not he/she thinks releasing certain information to a specific person or entity might be harmful to you (i.e. – with the U.S. Dept. of Defense).
7. If a court of law issues an order (not a subpoena) for release of your records, your therapist is legally required to comply with the order. However, it is rare for a court to issue an order overriding therapist/client confidentiality.
8. If you file a malpractice complaint against your therapist and his/her attorney believes it in his/her best interests to use all or parts of your treatment records for his/her legal defense.
9. While your therapist will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment

session, other patients in the treatment area may see, or overhear discussion of you discussing your health information.

ADOLESCENTS & PARENTS/GUARDIANS

Although an adolescent client's guardians hold the right to review the client's records, and to know about all aspects of the client's treatment and what is discussed in sessions, your therapist requests that guardians not exercise this right. Instead, your therapist requests guardians' agreement that he/she only breach confidentiality if and when he/she becomes aware of the adolescent client being in, or placing others in, imminent danger of physical harm. Examples include but are not limited to: client experiencing suicidal or homicidal thoughts, medically serious self-injury or eating disorder symptoms, substance abuse with potentially dangerous medical consequences, or driving under the influence of alcohol or drugs.

COMMUNICATION BETWEEN SESSIONS

When your therapist leaves a message for you in any form, he/she will attempt to be as vague as possible while conveying necessary information.

Email: Email accounts may be hacked, and any company/individual on whose server you access your email has the right to review your messages (even with personal accounts). Please review the Email Consent Form, if you are wanting to communicate with your therapist via email.

Text Messages: While text messaging is convenient, your therapist will refrain from using text message to communicate with you. As a client, you may use text to cancel or reschedule appointments with your therapist. If you initiate contact with your therapist via text message, your therapist will only provide minimal responses to inform you that the text was read. Your therapist will not text with you outside of scheduling purposes. h

****Please note that email, voicemail, and text messaging are not to be used in emergency or crisis situations. In such situations, please directly call 911.****

Public Encounters: To protect your privacy, if your therapist sees you in public (outside of the office building), he/she will not in any way acknowledge knowing you unless you do first. If you do acknowledge your therapist, he/she will not disclose to anyone else present how he/she knows you; it is your decision whether or how to introduce him/her to anyone else present.

CLIENT RECORDS

Your clinical file will consist of (1) legal forms such as this document, (2) clinical progress notes, and (3) a record of visits and payments. Clinical progress notes will contain enough information about your treatment to justify it, should such justification ever become an issue. Since your therapist functions independently in his/her practice, nobody else will have access to your records except under the conditions described on this form. You have the right to view your records at any time. However, your therapist has the right to provide you with the completed records or a summary of their contents and to require a meeting in which he/she can orally review the records with you as you view them for the first time. Providing only a summary of your records and holding such a meeting is meant to prevent any potential harm to you or our relationship as a result of any misunderstanding of the notes.

AMENDMENTS TO THIS POLICY

Your therapist reserves the right to change the terms of this notice and will inform you immediately in person or by mail of any changes. You then have the right to object or withdraw from treatment, as you believe is necessary.

CONCERNS/COMPLAINTS

Please contact your therapist with any questions or concerns about the privacy/security of your PHI. If you choose, you may file a complaint with us or with the Secretary of the Department of Health and Human Services.

REQUIREMENT FOR WRITTEN AUTHORIZATION

I will obtain your written authorization before using your health information or sharing it with others outside my practice, except as described in this Notice. Uses and disclosures of health information that require your written authorization include: most uses and disclosures of psychotherapy notes, most uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information. Other uses and disclosures not described in this Notice or otherwise permitted by HIPAA will be made only with your written authorization. You may also initiate the transfer of your records to another person by completing a written authorization form. If you provide me with written authorization, you may revoke that written authorization at any time, except to the extent that I have already relied upon it. To revoke a written authorization, please inform me in writing.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & HIPAA AGREEMENT

By signing below, you acknowledge you have read and understand the information in this disclosure, that you have discussed its contents with your therapist, and that you are entering (or are entering your dependent child/ward) into therapy in agreement with this policy. You also acknowledge being provided a copy (printed or online) of this document for your records.

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Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority