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Notice of Privacy Practices

(effective date March 15, 2021)

THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY and indicate that you have received this notice by signing and dating the included form. If you are under 18 years of age, your parent or guardian must sign for you and handle your privacy rights with you.

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

As part of the process of counseling, we will be keeping a clinical record of your care. This clinical record includes printed and electronic documents such as intake questionnaires, treatment plans, counseling sessions, assessments, and payment information; it comprises your protected health information (PHI). We need this record to provide you with quality care and to comply with certain legal requirements. We understand that information about you and your health care is personal and we are committed to protecting your privacy. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared. We are required by law to:

- Make sure that protected health information (PHI) that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect. If the terms of this notice are changed, the new privacy notice will be available upon request, in our office, and on our website.

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

Use. “Use” of your PHI refers to situations when information is shared internally, within our practice.

Disclosure. “Disclosure” of your PHI refers to situations when information is shared externally, with those outside our practice.

Consent. By law, we may not treat you unless you give us written authorization to use your PHI for the purposes of treatment, payment, and healthcare operations. Your written authorization is given by signing this Notice of Privacy Practices. Gwen Ashby Counseling, LLC also requires your written consent by signing our “Informed Consent Notice.” Once you give consent by signing this form, federal privacy rules allow us to use and disclose your PHI for treatment, payment, and healthcare operations.

Treatment. We may use and disclose your PHI to provide, coordinate or, manage your mental health care and related services: for example, if we consult with other health care providers regarding your treatment with us, or if we refer you to another professional such as a physician or psychiatrist for additional services.

Payment. We may use and disclose your PHI to bill you, your insurance provider, or others for your treatment. We may contact your insurance company to check what your insurance covers. They may request information from us, such as dates of services, your diagnoses, treatment received and planned, and progress made. We may also disclose limited PHI to consumer reporting agencies related to collection of payments owed us.

Healthcare Operations. We may use or disclose your PHI for healthcare operations to ensure you receive quality care: for example, to review our services and to evaluate the performance of our staff as it relates to your care.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, and healthcare operations, we will obtain an authorization from you before releasing this information. We will also need to obtain a separate and specific authorization before releasing your **psychotherapy notes**. Psychotherapy notes are notes we have made about our conversation during a private, group, joint, or family counseling session. These notes are kept separate from the rest of your clinical record, and they are given a greater degree of protection from PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

USES AND DISCLOSURES REQUIRING NEITHER CONSENT NOR AUTHORIZATION

We are permitted to use and disclose PHI without your authorization in the following circumstances:

- **Child Abuse:** If, in our professional capacity, we know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, we are required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or a municipal or county peace officer.

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- **Elder and Domestic Abuse:** If we have reasonable cause to believe that an elder is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, we are required by law to immediately report such belief to the County Department of Job and Family Services.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release this information without written authorization from you or your persona or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If we believe that you pose a clear and substantial risk of imminent serious harm to yourself or another person, we may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to us an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and we believe you have the intent and ability to carry out the threat, then we are required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).
- **Worker's Compensation:** If you file a worker's compensation claim, we may be required to give your mental health information to relevant parties and officials. HIPAA: Notice of Privacy Practices Revised 01-30-2020
- **Other:** When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the State's confidentiality law. This includes certain narrowly defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

USE AND DISCLOSURE WITH OPPORTUNITY TO AGREE OR OBJECT

For Notification and Other Purposes. We may rely on your informal permission to share your PHI with family, friends or other individuals you identify as relevant to your care or payment for care. Informal permission may be obtained by asking you outright, or by circumstances that clearly give you the opportunity to agree, acquiesce, or object. You may inform us whom you may wish us to contact, and the limits of what we may share. We will honor your wishes as long as your request is not against the law. In an emergency situation, wherein you may be incapacitated or not available, we may use and disclose your PHI if, in our professional judgement, it is in your best interest to do so.

YOUR PERSONAL HEALTH INFORMATION RIGHTS

1. **Right to Request Restrictions.** You have the right to ask us not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request but will do so if we are able (e.g., if it is not against the law).
2. **Right to An Accounting of Disclosures.** You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receipt. You may request records from up to six years ago.
3. **Right to Amend.** If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you may request its correction in writing. If we deny your request, you have the right to file a statement of disagreement, which will be kept in your clinical record.
4. **Right to Inspect and Copy.** You may make a written request to inspect and copy your PHI. We may deny your request in limited circumstances, including psychotherapy notes, information for use in civil, criminal, and administrative action, and access to that PHI which is limited by law. If we deny access, you have the right to seek a second opinion from another licensed mental health professional. We reserve the right to charge fee for the costs of gathering, copying, and mailing your request.
5. **Right to Request Alternative Communication.** You have the right to specify in writing how or where you wish us to send confidential communications. For example, you may request that we communicate with you through a designated address or phone number only, or that we send communications in a closed envelope rather than a post card. We will accommodate all reasonable requests.
6. **Right to a Paper Copy.** Upon request, you have the right to obtain a paper copy of this notice, even if you have agreed to receive this notice electronically.

COMPLAINTS

If you are concerned about how we have handled your PHI, or disagree with a decision we made about access to your records, you may file a complaint with Gwen Ashby, M.S., L.P.C. at Gwen Ashby Counseling, LLC. You may also file a complaint with the Office for Civil Rights of the U.S. Department of Health and Human Services at: Centralized Case Management Operations, DHHS, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201 <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>



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EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on **March 15, 2021.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE of PRIVACY PRACTICES

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Name (PRINTED)

Client Street Address (PLEASE PRINT)

City, State

Zip Code

Client Signature
(or client's personal representative)

Date

Name of Personal Representative (if applicable)

Description of representative's authority to act for the client (if applicable)