

LICENSED PSYCHOLOGIST

NOTICE OF 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.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individual health information used or disclosed by me in any form, whether electronically, on paper, or orally, are kept strictly confidential. This Act gives you, the patient, the right to understand and control how your health information is used. As required by HIPAA, I have prepared this explanation of how I will maintain the privacy of your health information and how I may use or disclose your health information. I reserve the right to change my privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes in my privacy practices and the new terms of the Notice effective for all health information that I maintain including health information created or received before making the changes. Before making a significant change in my privacy practices, I will change this Notice and make the new Notice available upon request. You may request a copy of the Notice at any time.

The law protects the privacy of all communications between a patient and a psychologist. 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 and/or Pennsylvania law. However, in the following situations, no authorization is required:

- I may use or disclose your health information to a physician or healthcare provider providing treatment for you. In addition, I may occasionally find it helpful to consult other health and mental health professionals about a case. During such a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. I am not required to inform you about these consultations unless I feel that it is important to our work together.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- 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 written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

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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. These situations are unusual in my practice. They are as follows:

- If I have reason to believe that a child has been subjected to abuse or neglect, the law requires that I file a report with the appropriate government agency, usually the local office of the Department of Public Welfare. Once such a report is filed, I may be required to provide additional information.
- If I know that a patient has a propensity for violence and the patient indicates that he/she has the intention to inflict imminent physical injury upon a specified victim(s), I may be required to take protective actions. These actions may include establishing and undertaking a treatment plan that is calculated to eliminate the possibility that the patient will carry out the threat, seeking hospitalization of the patient and/or informing the potential victim or the police about the threat.
- If I believe that there is a imminent risk that a patient will inflict serious physical harm or death on him/herself, or that immediate disclosure is required to provide for the patient's emergency health care needs, I may be required to take appropriate protective actions, including initiating hospitalization and/or notifying family members or others who can protect the patient.

If any of the above situations arise, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It typically includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that disclosure is reasonably likely to endanger the life or physical safety of you or another person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical Records, you have a right of review, which I will discuss with you upon request.

In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of

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your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

You should also be aware that although it is your responsibility to pay me directly, in order to receive reimbursement from your health insurance company I may be required to provide information relevant to the services that I provide to you. I am required to provide them with a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. If I believe that your health insurance company is requesting an unreasonable amount of information, I will call it to your attention and we can discuss what to do. You can instruct me not to send requested information, but this could result in claims not being paid and an additional financial burden being placed on you. Once the insurance company has this information, it will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies generally claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

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Eric B. Spiegel, Ph.D.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan, and direct my treatment and follow-up.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that you may change your Notice of Privacy Practices from time to time and that I may contact you at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Patient Name: _____

Signature: _____

Date: _____

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