BEECHCROFT DENTAL

HIPAA Notice of Privacy Practices

Patient Consent Form

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. Effective 9/24/2013.

I am totally committed to maintaining clients' confidentiality. I will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession. This notice describes my policies related to the use and disclosure of your healthcare information.

Use and disclosure of protected health information is for the purpose of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes. The practice provides this form to comply with the *Health Insurance Portability and Accountability Act of 1996 (HIPAA).*

Treatment: I may need to use or disclose health information about you to provide, manage, or coordinate your care or related services. This could include consultants and potential referral sources. For instance,

this may include a doctor you were referred to in order to help the doctor properly diagnose and treat you.

Payment: I may use your PHI as needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

Healthcare Operations: I may need to use information about you to review my treatment procedures and business activity. Information may be used for certification, compliance, and licensing activities. Other examples of this use would be contacting you in regards to scheduling appointments.

Other uses or disclosures of your information which do not require your consent: There are some instances where I may be required to use and disclose information without your consent. For example (but not limited to): Information you and/or your child(ren) report about physical or sexual abuse; then by Florida State Law I am required to report this to the Department of Children and Family Services; Information provided by you that informs us that you are in danger of harming yourself or others; Information to remind you about or to reschedule appointments or treatment alternatives; Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order; I may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.

What are your rights?

The following are your rights with respect to your mental health information:

1. You have the right to ask to restrict uses or disclosures of your mental health information for treatment, payment, or health care operation. You have the right to also ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. Please note that while I will try to honor your request and will permit requests consistent with my policies, I am not required to agree to any restriction.
2. You have the right to ask to receive confidential communications of information in a different manner or at a different place (for example: by sending it to a P.O. Box rather than your home address).
3. You have the right to see and obtain a copy of your mental health information that may be used to make decisions about you such as claims and case management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health

information. In certain limited circumstances, I may deny your request to inspect and copy your mental health information if I believe that disclosure of certain information contained in your mental health records may be harmful to your condition or impede further treatment of your condition. This decision will be binding.
4. You have the right to amend information I maintain about you if you believe the mental health information about you is wrong or incomplete. If I deny your request, you may have a statement of your disagreement added to your mental health information.
5. You may have the right to receive an accounting of disclosures of your information made by me.
6. You have the right to a paper copy of this Notice. You may ask for a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.
7. If you believe that your rights have been violated, you may notify the Secretary of the U.S. Department of Health and Human Services if you have any complaint to make. I will not take any action against you for filing a complaint.

I reserve the right to change the terms of this notice and will inform you in writing of any changes. You then have the right to object or withdraw as provided in this notice.

Patient name: _____ Date: _____