

VERONICA SULLIVAN, PH.D.
LICENSED PSYCHOLOGIST
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NOTICE OF PRIVACY PRACTICES

(Health Insurance Portability and Accountability Act provisions)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

Protecting Your Privacy...

Psychologists have always managed psychological records with great concern for privacy and confidentiality. Although the security of psychological records has continuously been addressed by Psychology Codes of Ethics as well as State and Federal laws, the rules have been strengthened and made more transparent by the provisions of the Health Insurance Portability and Accountability Act (HIPAA) which went into effect on April 14, 2002. The following information provides details about the provisions of HIPAA and your rights concerning privacy and your psychological records.

Who will observe these rules?

The following individuals are required by HIPAA to comply with the privacy rules:

- Your treating psychologist;
- Any secretary or receptionist who may have limited access to your identifying information (e.g., name, address, telephone number);
- Any billing agency or collection agency that handles information about you (e.g., name and address, diagnostic codes, treatment codes, consultation dates, but not actual clinical records).

YOUR RIGHTS REGARDING PSYCHOLOGICAL INFORMATION ABOUT YOU

As a patient or client in Dr. Sullivan's practice, you have the following rights:

THE RIGHT TO INSPECT AND OBTAIN A COPY OF YOUR PSYCHOLOGICAL RECORD

Professional records constitute an important part of the therapy process and help with the continuity of care over time. According to the rules of HIPAA, your treatment and consultations with Dr. Sullivan are documented in two ways. **The Clinical Record**, which is a required record that includes the date of your therapy sessions, your reasons for seeking treatment, your diagnosis, therapeutic goals, treatment plan, progress, medical and social history, treatment history, functional status, any past records from other providers, as well as any reports to your insurance carrier. **Psychotherapy Notes** are optional notes that are kept by some providers to document specific content or analyses of therapy conversations, how they impact on the therapy, and notes of your therapist that may assist in treatment. When used, Psychotherapy Notes are kept separately from your Clinical Record in order to maximize privacy and security.

You have the right to inspect and receive a copy of your Clinical Record. Viewing your record is best done during a professional consultation, rather than on your own, in order to clarify any questions that you may have at the time. You may be charged a nominal fee for accessing and photocopying the record. Psychotherapy Notes, however, if they are created, are never disclosed to third parties, HMOs, insurance companies, billing agencies, patients, or anyone else. They are for the use of the treating psychologist in tracking the many details of consultations that are too specific to be included in the Clinical Record. If your case manager or insurance company requests to see the psychotherapy notes, you have a choice about consenting (authorizing release of this information) or denying access

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to them. If you refuse, it will not affect your coverage or reimbursement in any way, and your insurance provider or HMO is obliged to provide payment as usual.

THE RIGHT TO REQUEST A CORRECTION OR ADD AN ADDENDUM TO YOUR PSYCHOLOGICAL RECORD

- **Correction:** If you believe that there is an inaccuracy in your clinical record you may request a correction. If the information is accurate, or if it has been provided by a third party (e.g., previous therapist, primary care physician, etc.), it may remain unchanged, and the request may be denied. In this case you will receive an explanation in writing, with a full description of the rationale.
- **Addendum:** You also have the right to make an addition to your record, if you think it is incomplete.

THE RIGHT TO AN ACCOUNTING OF DISCLOSURES OF YOUR PSYCHOLOGICAL INFORMATION TO THIRD PARTIES

You have the right to know if, when, and to whom your psychological information has been disclosed (exclusive of treatment, payment, and health care operations). However, you likely would already be aware of such disclosures, as you would have signed consent forms allowing for them (such as to other psychotherapists, primary care physicians, etc.). This accounting must extend back for a period of six years.

THE RIGHT TO REQUEST RESTRICTIONS ON HOW YOUR INFORMATION IS USED

You have the right to request restrictions on certain uses or disclosures of your psychological information. These requests must be in writing, and most likely will be honored, although in some cases they may be denied. This office does not use or release your protected health information for any purpose other than treatment, payment, healthcare operations, and other exceptions specified in this notice.

THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

You have the right to request that your therapist communicate with you about your treatment in a certain way, or at a certain location. For example, you may prefer to be contacted at work instead of at home, or on a cell phone, in order to schedule or cancel an appointment. Or, you may wish to receive billing statements at a Post Office Box, or at some other address.

THE RIGHT TO A COPY OF THIS NOTICE UPON REQUEST

You have the right to have a copy of this Notice of Privacy Practices.

THE RIGHT TO FILE A COMPLAINT

You have the right to file a complaint if you believe your privacy rights have been violated. You must do so in writing, and may address it directly to Dr. Sullivan or to the Secretary of the Department of Health and Human Services (address: Office for Civil Rights, 200 Independence Ave., S.W., Washington, D.C. 20201). Filing a complaint will not change the health care provided by this office in any way. If you have questions or concerns about this notice or your health information privacy, please do not hesitate to contact Dr. Sullivan at (518)-894-8263.

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HOW THIS OFFICE MAY USE AND DISCLOSE PSYCHOLOGICAL INFORMATION ABOUT YOU

FOR TREATMENT

Dr. Sullivan will access your record and use psychological information about you to assist in the continuity of your treatment services. This information will not be shared with other health care professionals; unless you specifically request it or agree to it, and sign a consent form to that effect.

FOR PAYMENT

This office may use and disclose information about you for billing purposes. This generally is restricted to your name and other personal identifiers (address, relevant identifying information, or other needed information), diagnostic and treatment codes, dates of services, and any similar information.

FOR HEALTH CARE OPERATIONS

Dr. Sullivan may share basic identifying information with an administrative assistant or other office staff to assist in scheduling and treatment procedures. This would not normally include the contents of your psychological record.

AS REQUIRED BY LAW

It is possible (though unlikely) that the Department of Health and Human Services may review how this office complies with the regulations of HIPAA. In such a case, your personal health information could be revealed as part of providing evidence of compliance.

BUSINESS ASSOCIATES

This office may contract with a billing agency or attorneys to attend to business issues on an as-needed basis. In this case, there will be a written contract in place with the agency requiring that it maintain the security of your information in compliance with the rules of HIPAA.

RESEARCH

This office is currently not participating in any research studies. However, if research is conducted through this office in the future, you would be informed of the nature of the research, have an opportunity to read and review an Informed Consent describing the research study thoroughly, and ultimately have the opportunity to accept or decline participation. You would never be obligated to participate in a research project and your choice to decline research involvement would not affect your treatment in any way.

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CHANGES TO THIS NOTICE

Please note that this privacy notice may be revised from time to time. You will be notified of changes in the laws concerning privacy or your rights as we become aware of them. In the meanwhile, please do not hesitate to raise any questions or concerns about confidentiality with Dr. Sullivan.

Your signature below indicates that you have read and understand the information in this document and agree to abide by its terms. Please print an additional copy for your records.

Printed Name of Client

Date

Signature of Client