NOTICE OF PRIVACY POLICIES AND HANDLING OF PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), is a federal law that defines Protected Health Information (PHI) and mandates its protection by the providers of certain health care services. HIPAA gives you significant new rights to understand and control how your health information is protected and used. The law required that you be provided with this Notice of the legal duties and the privacy practices with respect to your PHI (Protected Health Information). We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so. For purposes of this Notice "us", "we" and "our" refers to any practitioner or employee at Discovering Destinies, Inc. and Erica H. Epstein, Licensed Marriage and Family Therapist License #MT3814, and Eric B. Epstein, Esq., Licensed Marriage and Family Therapist License #MT3842, and "you" or "your" refers to our clients (or their legal representative as determined by us in accordance with Florida informed consent law). The Florida Information and Protection Act of 2014, as amended (FIPA), also provides for certain provisions regarding the protection of your health information.

These laws, individually and collectively, require us to maintain the confidentiality of all your health care records and other individually identifiable health information used by or disclosed to us in any form, whether electronically, on paper, or orally.

OUR PLEDGE REGARDING HEALTH INFORMATION: We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by us. This notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights to the health information we keep about you and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to:

(i) Make sure that protected health information ("PHI") that identifies you is kept private;
(ii) Give you this notice of our legal duties and privacy practices with respect to health information;
(iii) Follow the terms of the notice that is currently in effect;
(iv) We can change the terms of this Notice, and such changes will apply to all information we have about you.

LIMITS ON CONFIDENTIALITY:** The law protects the privacy of all communication between a patient and mental health professional. In most situations, we 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 FIPA. There are some situations where we are permitted or required to disclose information without either your consent or authorization. If such a situation arises, we will limit my disclosure to what is necessary. Reasons we may have to release your information without authorization:

1. If you engage 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. We cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if we receive a subpoena of which you have been properly notified and you have failed to inform us that you oppose the subpoena. If you engage in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order us to disclose information. The psychologist-patient privilege is your right and you must be the one to enforce it or instruct us to invoke it.

2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, we may be required to provide it for them.

3. If a client (or someone acting on behalf of the client or with the information provided by the client) files a complaint or lawsuit or claim against us, or if we have a good-faith belief that a client (or someone acting on behalf of the client or with the information provided by the client) may file a complaint or lawsuit or claim against us, we may disclose relevant information regarding that patient in order to defend ourselves.

4. If a patient files a worker's compensation claim, and we are providing necessary treatment related to that claim, we must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier, or an authorized qualified rehabilitation provider.

5. We may disclose the minimum necessary health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates generally sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

6. You agree, understand, and expressly consent that your confidential information may be shared, at our sole discretion, with any employee, agent, officer, or contractor associated with and/or employed by us or Discovering Destinies, Inc., including, without limitation, Erica H. Epstein, LMFT, as well as Eric B. Epstein, Esq., LMFT.

7. For Insurance Clients: We may disclose health information, session notes, billing, insurance company name and insurance member ID/Group number(s), credit card, first and last name, phone number, email address, date of birth, contact information, and any other information necessary to verify insurance benefits, handle administrative billing tasks, obtain payment from your insurance company, etc. to Headway Florida Behavioral Health Services, P.A. - which performs certain administrative/billing services on our behalf - and your insurance company.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm, and we may have to reveal some information about a patient's treatment:

1. If we know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that we file a report with the Florida Abuse Hotline. Once such a report is filed, we may be required to provide additional information.

2. If we know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that we file a report with the Florida Abuse Hotline. Once such a report is filed, we may be required to provide additional information.

3. If we believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, we may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

You agree and acknowledge the provisions regarding confidentiality and the use of text/sms/email/phone communications as contained in the document called Informed Consent & Agreement To Participate In Treatment – which provisions are incorporated by reference into this Notice.

CLIENT RIGHTS AND THERAPIST DUTIES:

Use and Disclosure of Protected Health Information:

· ***For Treatment –*** We use and disclose your health information internally during your treatment. If we wish to provide information outside of our practice for your treatment by another health care provider, we will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.

· **For Payment** – We may use and disclose your health information to obtain payment for services we provide to you or to respond to any credit card dispute or charge-back.

· ***For Operations*** – We may use and disclose your health information within Discovering Destinies, Inc. as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

· ***For Appointment and Services*** – To run our office efficiently, you may be contacted by telephone, mail, or e-mail. Please inform the office of the numbers that you want to be reached at and the procedure you want us to follow when or if another individual answers the call. We will automatically leave a message with the numbers you provide and mail information to the address you list with us unless you indicate otherwise. Notification by you must either be in writing or indicated specifically on your other paperwork provided to you by the office. If you check the appointment reminder checkbox for any contact of yours to also receive appointment notifications, we will send those reminders to such person.

· ***For Minors or Incapacitated Clients*** – To Individuals involved in your care such as your parents, if you are a minor, or your conservator.

Client's Rights:

· ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.

· ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

· ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.

· ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

· ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing essential information, you can ask us to make certain changes, also known as amending, to your health information. You must make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is and if we refuse to do so, we will tell you why within 60 days.

· ***Right to a copy of this notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.

· ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. At your request, we will discuss with you the details of the accounting process.

· ***Right to choose someone to act for you*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.

· ***Right to Choose*** – You have the right to decide not to receive services with us. If you wish, we will provide you with the names of other qualified professionals.

· ***Right to Terminate*** – You have the right to terminate therapeutic services with us at any time without any legal or financial obligations other than those already accrued. We ask that you discuss your decision with us in session before terminating or at least contact us by phone letting us know you are terminating services.

· ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. We will discuss whether we think releasing the information in question to that person or agency might be harmful to you.

Clinician's Duties:

● We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will provide you with a revised notice.

● A copy of this Notice and any updated or revised versions of this Notice is available upon request, in our office, and is available on our website (www.discoveringdestinies.com).

COMPLAINTS: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact me, the State of Florida Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

***EFFECTIVE DATE OF THIS NOTICE**:** This notice went into effect on September 1, 2021.

ACKNOWLEDGMENT OF RECEIPT:

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.

I ACKNOWLEDGE THAT I AM THE CLIENT AND/OR PARENT/GUARDIAN OF THE MINOR CHILD(REN) WHO WILL ALSO BE SEEN IN TREATMENT AND ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND ALL THE TERMS, POLICIES, AND INFORMATION CONTAINED HEREIN AND AGREE TO ABIDE BY THEM. I ALSO ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH AMPLE OPPORTUNITY TO ASK QUESTIONS AND SEEK CLARIFICATION OF ANYTHING UNCLEAR TO ME PRIOR TO SIGNING THIS/THESE DOCUMENTS.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT ON MY BEHALF AND ON BEHALF OF ANY OF MY MINOR CHILD(REN) WHO WILL ALSO BE SEEN BY DISCOVERING DESTINIES, INC.

Print Your Name Above

Sign Your Name Above

Print Today's Date Above

Print Child's Name(s) Above (if applicable)

(rev.09-01-2021)