

INNOVATIVE INTERVENTIONS, LLC

**Methodist Medical Plaza East
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Notice of Policies and Practices at Innovative Interventions, LLC, to Protect the Privacy of Your Health Information.

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU (WHICH INCLUDES YOUR MINOR-AGED CHILD, IF HE/SHE IS THE IDENTIFIED PATIENT) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
 - ✧ Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment includes when I consult with another health care provider, such as your family physician or another psychologist.
 - ✧ Payment is when I obtain reimbursement for your healthcare.
 - ✧ Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Uses" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session (or telephone conversations pertinent to any counseling session), which I have kept separate from the rest of your clinical record. These notes are given a greater degree of protection than 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) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If I have reasonable cause to believe that a child has been abused, I must report that belief, as required by law, to the appropriate authorities.
- Adult and Domestic Abuse: If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief, as required by law, to the appropriate authorities.
- Health Oversight Activities: If a governmental agency, such as the Indiana Attorney General's Office, is conducting an investigation into my practice, then I am required to disclose PHI upon receipt of a subpoena.
- Judicial and Administrative Proceedings: If the patient is involved in a court proceeding and a request is made for information about the professional services I provided you and/or the record thereof, such information is privileged under state law, and I will not release information without the written authorization of you (or your 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 I determine, or pursuant to the standards of my profession should determine, that you present a clear and immediate probability of physical harm to yourself, to other individual(s), or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, medical or law enforcement personnel, or other appropriate authorities.
- Worker's Compensation: If you file a worker's compensation claim, I may be required to disclose PHI, such as your diagnosis and treatment records, to relevant parties or officials. I may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of PHI. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know you are seeing me for counseling. Upon your request, I will send correspondence to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you as long as the PHI is maintained in the clinical record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- Right to a Paper Copy – You will be provided a paper copy of this notice from me and will be asked to acknowledge receipt of this notice.

Therapist’s Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a written copy of those revisions at the next appointment or by mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your clinical records, you may contact the administrative office at the above phone and/or address.

You may also send a written complaint to the Indiana State Department of Health and the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate addresses upon request.

You have specific rights under the Privacy Rule. I will take no retaliatory action against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

The Notice, pursuant to the Health Insurance Portability and Accountability Act (HIPAA), has been in effect since April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in person or by mail.

Acknowledgement of Review, Understanding, and Receipt of a paper copy of the **“Notice of Policies and Practices at Innovative Interventions, LLC, to Protect the Privacy of Your Health Information”** from the therapist:

I have reviewed, understand, and received a paper copy of the **“Notice of Policies and Practices at Innovative Interventions, LLC, to Protect the Privacy of Your Health Information”** from the therapist.

PRINT: Patient Name	DOB	Age
Patient Signature	Date	Parent/Guardian/ Representative Signature
Witness/Therapist Signature	Date	Legal Authority of Representative

Print: Therapist Name and Credentials