***ARLENE C. GERSON, PHD***
***9650 SANTIAGO ROAD, SUITE 3***
***COLUMBIA, MD 21045***
***443-827-3175***

# *NOTICE OF PRIVACY PRACTICES*

## *THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.*

This Notice of Privacy Practices provides you with important information about confidentiality and the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights regarding the information that you share with me. HIPAA was designed to improve the efficiency of health care services by standardizing electronic data and to protect privacy of this data by imposing uniform procedures and standards. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of your Protected Health Information (PHI) for treatment, payment, and health care operations. Please note that although HIPAA dictates a number of ways that I may share your Protected Health Information, only under the most unusual circumstances will I release any information without your prior knowledge and authorization. Please read this over carefully and notify me if you have any questions or concerns. Each health care provider is required to appoint a Privacy Officer. Given that I am a solo practitioner, I serve as the Privacy officer for my practice. Please sign the last page, indicating that you understand and agree to these terms of services. Thank you.

## CONFIDENTIALITY AND LIMITS ON CONFIDENTIALITY

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 with your written consent. However, there are some limits to confidentiality that you need to be aware of. Please understand that if any situation as described below arises, I will make every effort to fully discuss the situation with you before taking any action and I will limit my disclosure as much as possible.

1) *Serious Threat to Health or Safety*-If a patient threatens to harm himself or herself, I may be obligated to seek hospitalization for him or her, or to contact family members or others who can help provide protection. If a patient communicates a specific threat of immediate serious physical harm to an identifiable victim, and I believe he or she has the intent and ability to carry out the threat, I am required to take protective actions. These actions may include notifying the potential victim or his or her guardian, contacting the police, or seeking hospitalization for the patient.
2) *Child Abuse*-If I have reason to suspect that a child is abused or neglected, the law requires that I file a report with the appropriate governmental agency, usually the Department of Social Services. Once such a report is filed, I may be required to provide additional information.
3) *Adult Abuse and Domestic Violence*-If I have reason to suspect that an adult is abused, neglected or exploited, the law requires that I file a report to the Department of Welfare or Social Services. Once such a report is filed, I may be required to provide additional information.
4) *Judicial and Administrative Proceedings*-If a patient is involved in a court proceeding and a request is made for information, I cannot provide any information without written authorization, or a court order. However, if a subpoena is served on me with appropriate notices, I may have to release the information requested. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
5) *Health Oversight Activities*- If a government agency is requesting information for health oversight activities, I may be required to provide it for them.

6) *Peer Consultation*- I may occasionally find it helpful to consult with other mental health professionals about my work with a client. During a consultation, names and other identifying information are not used. Discussion is limited to general information, diagnosis, and treatment. The other professionals with whom I may consult are also legally bound to keep the information confidential. Although I do not customarily tell clients about these consultations, I will note all consultations in your Clinical Record.
7) *When authorized under other sections of Section 164.512 of the Privacy Rule and/or the state's confidentiality law*-This includes certain narrowly defined disclosures to law enforcement agencies, to a coroner or medical examiner, for public health purposes relating to disease or FDA regulated products, and for national security and intelligence.

## CLIENT RIGHTS

As a patient, you have certain rights regarding your health information. In fact, HIPAA provides you with several new or expanded rights with regard to your PHI. I am happy to discuss any of these rights with you.

1) *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*-You have the right to ask me to communicate with you about your health and related issues in a particular way or place that affords you the most privacy. You have the right to determine the location to which protected information disclosures are sent. For example, you can ask that I do not call you at work, or that I do not identify myself when I call you at home, etc. I will do my best to accommodate your requests.
2) *Right to Restrict Restrictions*- You have the right to ask me to limit what I tell others involved in your care or in the payment of your care, such as family members and friends. Although your request does not necessitate agreement on my part, I will try to be most reasonable while also acting in the most legal and ethical manner. Either way, I will inform you about my intentions and the reasons for them.
3) *Right to Restrict Disclosure When You Have Paid for Your Care Out-of-Pocket*- You have the right to restrict certain disclosure of PHI to a health plan when you pay out-of-pocket in full for my service.
4) *Right to Inspect and Copy*-You have the right to inspect and obtain a copy (or both) of PHI in your clinical and billing records. Should you care to do so, I will inform you of the process to obtain a copy of and/or inspect PHI information. I may deny your access to PHI if I believe the disclosure of the records will be injurious to your health.
5) *Right to Amend*-You have the right to ask me to amend your record. Should you care to do so, you would have to submit your request in writing.
6) *Right to an Accounting*-You have the right to request an accounting of most disclosures of your PHI that you have neither consented to nor authorized.
7) *Right to a Paper Copy*- You have the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures.

## QUESTIONS AND CONCERNS

As the privacy officer, I am responsible for responding to any questions or concerns you may have regarding your privacy rights. If you believe there has been a violation of the confidentiality or the privacy of your records, write me a letter explaining the problem and I will help clarify and fix the situation. If you are still not satisfied with my initial response or the problem continues, please notify me directly so I can investigate it further, fix it, and repair any damage that has been done. Bringing a problem to my attention will not in any way limit your care here or cause me to take any actions against you. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services or the Maryland Board of Examiners of Psychologists. I can provide you with the appropriate address upon request.

## EFFECTIVE DATE AND CHANGES TO THE PRIVACY POLICY

This notice will go into effect at the onset of treatment with me.
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 notify you of revisions and my website will contain a posting of the most recent Notice of Privacy Practices.

***ARLENE C. GERSON, PHD***
***9650 SANTIAGO ROAD, SUITE 3***
***COLUMBIA, MD 21045***
***703-732-1234***

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge that I received a copy of the Notice of Privacy Practices

Date: _____

Name of Patient: _____

Signature of patient or patient representative: _____

If this Acknowledgment is signed by a patient representative on behalf of the patient, please complete the following:

Name of patient representative: _____

Relationship to the patient: _____

This form will be retained in your Medical Record

_____
Arlene C. Gerson, PhD

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For Office Use Only

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I attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign Acknowledgement
____ Communications barriers prohibited obtaining the Acknowledgement
____ An emergency situation prevented us from obtaining the signed Acknowledgement
____ Other (Please Specify)

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