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Notice of Privacy Practices

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, specifically the Standards for Privacy of Individual Identifiable Health Information), 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. I am committed to your Privacy.

Individually identifiable information about your past, present, and/or future health or condition, the provision of health care to you, or payment for the health care is Protected Health Information (PHI). I am required by law to protect your PHI and to give you this Notice about my privacy practices that explains how, when, and why I may use and/or disclose your PHI. Additionally, I am required to follow the privacy practices described in this Notice.

The terms of this notice apply to all records containing your PHI that are created or retained by my practice. I reserve the right to revise and or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that my practice has created and/or maintained in the past, and for any of your records that I may create and/or maintain in the future. My practice has copies of this Notice in my office at all times. You may request a copy of my most current Notice at any time.

LIMITS ON CONFIDENTIALITY

Use of Your Protected Health Information (PHI): The information I collect from you will be used to benefit your treatment, collect payment, and/or to operate my practice. Your PHI may be used if I coordinate treatment or consult with your Psychiatrist, family physician or another health care provider; to facilitate care coordination; to assist you in collecting health-related benefits or services; and/or to communicate your needs to your support system at your request. Your PHI may be used to determine eligibility or coverage from your heath care provider. Your health care information may also be used in administrative activities such as contacting you with your scheduled appointment reminders, or audits and assessments of my practice.

Release of Information with your consent: In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. I require all parents and children 14 or older to sign releases when applicable. You may revoke all such authorizations 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. Situations that I may request you give advanced consent by signing a release of information include:

1. In order to coordinate treatment with your Psychiatrist or other mental health professionals.
2. If I need to consult with another mental health professional, in which case I would make every effort to avoid revealing your identity. Other professionals are also legally bound to keep information confidential.
3. If you are utilizing insurance to pay for my services, the insurance company often requires information about your therapy.

4. If for some reason you request I release your information, for example when seeking worker's compensation or benefits from some other program.

Release of Information with or without your consent: Here are some situations where I am permitted or required to disclose PHI without consent or authorization:

1. If I am court ordered to disclose information, or required by Federal, State, and/or Local law. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. I may also be required to testify in court or hearing about adoption, adult and/or child abuse/neglect, and/or other matters pertaining to the client's welfare.
2. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
3. If I have reasonable cause to suspect that a child has been or may be subjected to abuse or neglect, or observe a child being subjected to conditions or circumstances that would reasonably result in abuse or neglect the law requires that I file a report with the Kansas or Missouri Division of Family Services. Once such a report is filed, I may be required to provide additional information.
4. If I have reasonable cause to suspect that an elderly or disabled adult presents a likelihood of suffering serious physical harm and is in need of protective services, the law requires that I file a report with Department of Social Services. Once such a report is filed, I may be required to provide additional information.
5. If I believe that it is necessary to disclose information to protect against a clear and substantial risk of imminent serious harm being inflicted by the patient on him/herself or another person, I may be required to take protective action. These actions may include, initiating hospitalization and/or contacting the potential victim, and/or the police, and/or the patient's family.
6. If I am required to comply to laws related to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

If any of the following situations arise, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

Professional Consultation and Advanced Supervision: I obtain regular advanced supervision/consultation from a highly experienced Missouri Licensed Professional Counselor. I utilize advanced supervision as part of ongoing professional development, and quality assurance in my practice. If I discuss the services I am providing to a particular client in advanced supervision or as part of a professional consultation, I make every effort no avoid revealing identifying information about my client. The other professionals who I may consult with or seek supervision from are also legally bound to keep any shared information confidential. By signing the receipt of my Privacy Practices you are giving consent to my possible utilization of consultation or advanced supervision in regards to our work together. I will share information about these consultations only if I feel it is important to our work together. I will note all consultations specific to work with you in your Clinical Record.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you. Records include information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of

any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

Patient Rights: You have a right to request and receive confidential communications of PHI by alternative means and at alternative locations. You have the right to specify the phone number, email address, and mailing address you would like me to use in order to communicate with you.

Except in the unusual circumstance where disclosure is reasonably likely to endanger you and/or others or when another individual (other than another health care provider) is referenced and I believe disclosing that information puts the other person at risk of substantial harm, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Due to the professional language used in documentation, I recommend you utilize a scheduled visit to review your record with me. If you believe there is a mistake or omission from your PHI, you may request that a correction and/or addition be made to the record, as long as you provide a reason that supports your request for the amendment. Your request must be in writing for consideration. Changes will be made based on our agreement that revisions are accurate and complete.

You also have the right to restrict what information from your Clinical Records is disclosed to others; request an accounting of most disclosure of protected health information; determine the location to which protected information disclosures are sent; to have any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Notice of my privacy policies and procedures.

Questions and Concerns:

If you have questions about this notice, disagree with a decision I make about access to your records, or have another concerns about your privacy rights, you may contact me at the following address:

Laura Aube, MS, ATR-BC, LPC (Missouri)
Center for Creative Growth and Healing
406 West Pine Street
Suite O
Raymore, Missouri 64083
816-359-1885

If you believe that your privacy rights have been violated and wish to file a complaint with me/my office, you may send your written complaint to me at the address listed above.

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

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

This notice will go into effect on March 1, 2009.

I reserve the right to change the terms of this notice and to make the new notice provision effective for all PHI that I maintain. I will provide you with a revised notice within seven days, either in person or by mail.