

Notice of Privacy Practices

The Federal Health Insurance Portability and Accountability Act (HIPPA) require mental health professionals to issue this official Notice of Privacy. Please review this document carefully. This document explains how your private health information can be used and disclosed as well as how you can get access to this information. When you sign this document, it will represent an agreement between Anna Shaver LPC PLLC, its therapists and you.

Release of Information (ROI)

Anna Shaver LPC PLLC and its therapists may disclose medical information about you to doctors, other therapists, or others who are involved in your treatment only with your written authorization. *(see Release of Information form, fill out, and return to your therapist)*

Waiver of Liability and Limits of Confidentiality

The law protects the privacy of all circumstances between a client and a therapist. 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 HIPPA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follow:

Anna Shaver LPC PLLC and their therapists may occasionally find it helpful to consult other health and mental health professionals about a client. The other professionals are also legally bound to keep the information confidential. Your identity will remain anonymous. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together.

If a client seriously threatens to harm himself or herself, I may be obligated to seek hospitalization for him or her or to contact others who can help provide protection.

There are some situations in which I am permitted or required to disclose information without either your consent or authorization:

If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

If a government agency is requesting the information for health oversight activities, I may be required to provide it to them.

If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

If a patient files a workers' compensation claim, I must upon appropriate request provide records relating to treatment or hospitalization for which compensation is being sought.

If the client fails to pay for services I have rendered, I may be disclose relevant information in a suit seeking payment.

There are some situations in which Anna Shaver LPC PLLC and its therapists are legally obligated to take actions which the therapist believes are necessary to attempt to protect others from harm and the therapist may have to reveal some information about a client's treatment. These situations are unusual in [Anna Shaver LPC PLLC practice, but you should be aware of them:

If the therapist has cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that the therapist make a report to the appropriate governmental agency. Once such a report is filed, the therapist may be required to provide additional information.

If the therapist determines that there is a probability that the client will inflict imminent physical injury on him or herself, or another, or that the client will inflict imminent mental or emotional harm upon others, I may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the client. If such a situation arises, 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.

I have understood the waiver of liability and limits of confidentiality above and consent to my participation in the counseling process and I understand that I may withdraw my consent at any time.

Initials _____

If a client is a minor, I consent as the client's legal guardian to participation in the evaluation process. I understand that I may withdraw my consent at any time.

Initials _____

To Report a Problem

If you believe your rights have been violated you may file a written complaint to the Texas Board of Examiners of Professional Counselors at 1100 West 49th Street, Austin, TX 78756-3183 or call the LPC Board office at 1-800-942-5540.

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers, when applicable

Conduct normal healthcare operations such as quality reviews.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have received a copy of such notice if requested. I understand that Anna Shaver LPC PLLC has the right to change its Notice of Privacy Practices from time to time and that I may contact Anna Shaver LPC PLLC at any time at the address above to request a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Client Name: _____

Print Name

Date: _____

Parent/Guardian: _____

Relationship to Client: _____

Signature of Client or Parent if Client is Minor: _____