Richmond Cognitive Behavioral Treatment Center, LLC

Therapy office location: 1506 Willow Lawn Drive, Suite 200, Richmond, VA 23230

Notice of Privacy Practices

Effective January 1, 2019

The owner of Richmond Cognitive Behavioral Treatment Center, LLC hereafter referred to as "I", follows professional standards and laws to protect your privacy. Federal laws require I provide you with a notice of privacy practices. This notice describes how I may use medical information about you, how you can obtain access to this information, and what will happen if I have knowledge that there has been a breach regarding your protected health information. Please review it carefully and ask me if you have any questions. If I change or revise this notice, I am required by law to make the revised notice available to you,

By law, I am required to:

- Make sure medical information that identifies you is kept private;
- Provide to you this detailed Notice of my privacy practices relating to your protected health information;
- Abide by the terms of the Notice that are currently in effect; and
- Notify you following a breach of any of your unsecured protected health information.

I will ask for your written permission to share with or obtain information from others about you. However, by law, your psychotherapist, physician, and their administrative support may use and disclose information regarding your medical information without your authorization for the purpose of providing health care services to you, pay your health care bills, support the operation of the practice, and any other use required by law.

For treatment: I will use and disclose your protected health information in providing you with treatment and services. For example, I may use information about you to coordinate my services with others who are involved in your health care for referral purposes.

For payment: In certain circumstances, I may use and disclose your protected health information so that I can bill and receive payment for the treatment and services you receive. For billing and payment purposes where applicable, for example, I may disclose your protected health information to your representative, an insurance company, or another third party payor.

For health care operations: I may need to use or disclose information for my practice activities. For example, I may use your protected health information for business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating my practice.

I MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU FOR OTHER SPECIFIC PURPOSES

As required by law: I may disclose medical information about you when required to do so by federal, state, or local law.

Reporting Victims of Abuse, Neglect or Domestic Violence: If I believe that you have been a victim of abuse, neglect or domestic violence, I may use and disclose your protected health information to notify a government authority if required or authorized by law, or if you agree to the report.

Health Oversight Activities: I may disclose your protected health information to a health oversight agency for oversight activities authorized by law. These may include, for example, audits, investigations, inspections and

licensure actions or other legal proceedings. These activities are necessary for government oversight of the health care system, government payment or regulatory programs, and compliance with civil rights laws.

Judicial or Administrative Proceedings: I may disclose your protected health information in response to a court or administrative order. I also may disclose information in response to a subpoena, discovery request, or other lawful process; efforts must be made to contact you about the request or to obtain an order or agreement protecting the information.

Law Enforcement: I may disclose your protected health information for certain law enforcement purposes, including:

- as required by law to comply with reporting requirements;
- to comply with a court order, warrant, subpoena, summons, investigative demand or similar legal process; to identify or locate a suspect, fugitive, material witness, or missing person;
- when information is requested about the victim of a crime if the individual agrees or under other limited circumstances;
- to report information about a suspicious death;
- to report information in emergency circumstances about a crime; or
- when necessary to identify or apprehend an individual in relation to a violent crime or an escape from lawful custody.

Coroners, Medical Examiners, Funeral Directors and Organ Procurement Organizations: We may release your protected health information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

To Avert a Serious Threat to Health or Safety: I may use and disclose your protected health information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person, including situations related to abuse, neglect, or domestic violence. However, any disclosure would be made only to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces, I may use and disclose your protected health information as required by military command authorities. I may also use and disclose protected health information about foreign military personnel as required by the appropriate foreign military authority.

National Security and Intelligence Activities: Protective Services for the President and Others: I may disclose protected health information to authorized federal officials conducting national security and intelligence activities or as needed to provide protection to the President of the United States, certain other persons, or foreign heads of states, or to conduct certain special investigations.

Workers' Compensation: We may use or disclose your protected health information to comply with laws relating to workers' compensation or similar programs.

YOUR AUTHORIZATION IS REQUIRED FOR OTHER USES OF PROTECTED HEALTH INFORMATION

I will use and disclose protected health information (other than as described in this Notice or required by law) only with your written Authorization. You may revoke your Authorization to use or disclose protected health information in writing, at any time. If you revoke your Authorization, I will no longer use or disclose your protected health information for the purposes covered by the Authorization, except where I have already relied on the Authorization. Your Authorization is specifically required for the following types of uses and disclosures:

marketing, sale of protected health information, and psychotherapy notes.

USE AND DISCLOSURE OF PSYCHOTHERAPY NOTES

Psychotherapy Notes: The term "psychotherapy notes" means notes recorded by me documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Psychotherapy notes are stored separately from the rest of your medical record.

I must obtain your authorization to use or disclose psychotherapy notes, except:

- To carry out the following treatment, payment, or health care operations: (A) use by me of the psychotherapy notes for treatment; (B) use or disclosure by me for my own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or (C) use or disclosure by me to defend myself in a legal action or other proceeding brought by you;
- For the purposes of the Department of Health and Human Services in determining compliance with the privacy rule (HIPAA-Health Insurance Portability and Accounting Act);
- To an oversight agency for the lawful purpose related to legal and regulatory oversight of me;
- To a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death, or other duties authorized by law;
- To prevent a serious threat to your health or safety or the health or safety of the public or another person, including situations related to abuse, neglect, or domestic violence. However, any disclosure would be made only to someone able to help prevent the threat.
- As otherwise required by law;

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding your protected health information:

Right to Request Restrictions: You have the right to request restrictions on our use or disclosure of your protected health information for treatment, payment or health care operations. You also have the right to restrict the protected health information I disclose about you to a family member, friend or other person who is involved in your care or the payment for your care. Unless as otherwise provided below, if I agree to your requested restriction, I am required to abide by your requested restriction, unless the release of records is required by law, or the release of information is needed to provide you emergency treatment. I may not be able to agree to all requested restrictions.

Right to Receive Confidential Communications: You have the right to receive communications about your protected health information from us confidentially and by an alternate means or at an alternative location. For example, you may request to receive communications regarding your protected health information at a post office box, rather than at your residence. You must make this request in writing.

Right to see and copy information: You may see and receive copies of your information maintained in your designated record. You must submit your request to see or copy your protected health information in writing to me. There are situations in which your request may be denied.

Right to request amendment of your information: You may request that any protected health information that I maintain about you be amended or changed. You must submit your request to amend or change your protected health information in writing and must include the reason for the amendment or change. I may deny your request if the information:

- was not created by me, unless the originator of the information is no longer available to act on the request;
- is not part of the protected health information maintained by or for me;
- is not part of the information to which you have a right of access;
- is already accurate and complete, as determined by me.

If I deny your request for amendment, I will give you a written denial including the reasons for the denial and will describe your rights for further review.

Right to an Accounting of Disclosures: You have the right to request an "accounting" of my disclosures of your protected health information. This is a listing of certain disclosures of your protected health information made by the me or by others on my behalf, but does not include disclosures for treatment, payment and health care operations or certain other exceptions. You must submit your request in writing.

To request an accounting of disclosures: You must submit a request in writing, stating a time period beginning after April 13, 2003 that is within six years from the date of your request. An accounting of disclosures will include, if requested, the disclosure date; the name of the person or entity that received the information and address, if known; a brief description of the information disclosed; a brief statement of the purpose of the disclosure or a copy of the authorization or request; or certain summary information concerning multiple similar disclosures. The first accounting provided within a 12-month period will be free; for further requests, I may charge you my costs.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

Right to Restrict Disclosure when Paying Out-of-Pocket: You have the right to restrict disclosure of your protected health information, relating to a specific health care service, to an insurance company for payment and health care operations purposes. We must comply with your request only if you or your personal representative has paid in full and up-front for that particular health care service.

COMPLAINTS

If you believe I have violated your privacy rights or you want to complain to me about my privacy practices, you may give me written notice and/or you may file a complaint with me or the U.S. Department of Health and Human Services at the following address:

Secretary of Health & Human Services
US Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20201

Should you file a complaint, you will not be retaliated against for filing a Complaint.

CHANGES TO THIS NOTICE

I will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. I reserve the right to change this Notice and to make the revised or new Notice provisions effective for all protected health information already received and maintained by me as well as for all protected health information I receive in the future. I will provide you with a revised Notice by mail.

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Therapy office location: 1506 Willow Lawn Drive Suite 200 Richmond, VA 23230
Mailing address: P.O. Box 17592 Richmond, Virginia 23226

Receipt and Acknowledgement of Notice of Privacy Practices

I acknowledge that I have received and have been given an opportunity to read Richmond Cognitive Behavioral Treatment Center, LLC's *Notice of Privacy Practices*. I understand that if I have any questions regarding this notice of my privacy rights, I may contact Dr. Wilder Schaaf, Ph.D. I understand that I may revoke, in writing, this authorization at any time except to the extent that action has already been taken in accord with it.

Client's Printed Name ______________________

Parent or Legal Guardian's Name (if Client is a Minor)______________________

Client's Signature (Parent or Legal Guardian if Client is a Minor) ___________________________________

Date__________________________

If you refuse to acknowledge receipt of this notice, check this box.