Wondering Together Counseling

Notice of Privacy Practices

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. THE WORD "YOU" AND "YOUR" ALSO REFERENCES YOUR CHILD, IF THEY ARE THE IDENTIFIED CLIENT.

Your health record contains Protected Health Information (PHI) to include information about you that relates to your past, present, or future physical or mental health or condition and related to health care services. This Notice of Privacy Practices describes how Wondering Together Counseling may use and disclose your PHI in accordance with applicable law and the *ACA Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

Mental Health Providers are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of this Notice of Privacy Practices at any time. Any changes will be effective for all PHI that is maintained at that time. If changes occur, I will provide you with a copy of the revised Notice of Privacy Practices through the SimplePractice portal or will provide one to you at your next appointment.

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 authorization. To help clarify these terms, the following definitions apply:

- **PHI**: Information in your health record that could identify you.
- **Treatment**: Actions I take to provide, coordinate, or manage your health care and other services related to your health care. An example of treatment is when I consult with another health care provider, such as your family physician, psychiatrist, or psychologist.
- **Payment**: Actions to obtain reimbursement for your health care.
- **Health care operations**: Activities that relate to the performance and operation of my practice, such as quality assessment, business related matters including audits and administrative services, case management, and care coordination.
- **Use**: Activities within my office and practice such as sharing, employing, utilizing, and assessing information that identifies you.
- **Authorization**: Your written permission to disclose confidential mental-health information. This requires your signature on a specific legally required form.

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with colleagues. Occasionally, I may need to consult with other professionals in their areas of expertise to provide the best treatment for you. Information about you may be shared in this context without using your name. Prior to disclosing any PHI to any other consultant, I will obtain your written authorization.

For Payment: Payment for services is due at the time of service. At this time, I am not paneled with any insurance company to bill them directly for your services. Information to be provided to a third-party

payer only with your consent: If you wish to obtain third party reimbursements for mental health services, certain information must be provided. Typically, that involves providing information about the dates of treatment, the type of treatment, and your diagnosis. You will process your own insurance claims and this information will be listed on the receipt I provide to you for that purpose. If you wish for me to provide more extensive information to your insurance company, you must provide written authorization. It is my policy to provide you an advance copy of the information being submitted to your insurance company.

For Health Care Operations: With your written consent, I may use or disclose, as needed, your PHI to support my business activities including, but not limited to, quality assessment activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g. billing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law: Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule. If I receive a subpoena from the Virginia Board of Social Work, I must disclose any PHI requested by the Board.

Without Authorization: Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. This also applies to your child if they are the identified client. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child or elder/vulnerable adult abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- If I have a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years or in the case of an elderly or other incapacitated or vulnerable individual.
- If a client threatens or attempts to commit suicide or otherwise conducts themselves in a manner in which there is a substantial risk of incurring serious bodily harm.
- If a client threatens grave bodily harm or death to another person or persons.
- If a court of law issues a legitimate court order or subpoena.
- If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney. This also applies to situations when disclosure is necessary to arrange for legal services to enforce or defend my legal rights.

Verbal Permission: I may use or disclose your information to family members or providers that are directly involved in your treatment with your verbal permission if disclosures are necessary for your continuity of care, time sensitive, or if signing a release of information is not possible.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time.

Telehealth: The laws that protect privacy and the confidentiality of mental health information also apply to telehealth services and the telecommunication software. I will utilize the SimplePractice platform for healthcare, a HIPAA compliant platform that uses video and audio technology through a webcam on the provider's device and the client's device to connect securely. SimplePractice has been selected to allow for the highest possible security and confidentiality of the content of your sessions. The client is responsible for creating and using additional safeguards when the computer used to access services may be accessed by others, such as creating passwords to use the computer, keeping their email and chat IDs and passwords secret, and maintaining security of their wireless internet access points.

Encounters in Public: If we see each other outside of the therapeutic space, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will speak with you briefly, however, it would not be appropriate to engage in any lengthy discussions in public or outside of the therapy space.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI maintained about you. To exercise any of these rights please submit your request in writing to me at leannah@wonderingtogether.com:

- **Right of Access to Inspect and Copy:** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to the client.
- **Right to Amend:** If you feel that the PHI, I have about you is incorrect or incomplete you may ask me to amend the information although I am not required to agree to the amendment.
- **Right to an Accounting of Disclosures:** You have the right to request an accounting of the disclosures that I make of your PHI.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation of the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.
- **Right to Request Confidential Communication:** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
- **Right to Copy of this Notice:** You have the right to a copy of this notice.

COMPLAINTS

If you believe that I have violated your privacy rights, you have the right to file a complaint in writing with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington D.C., 20201 or by calling 202-619-0257. **You will not be retaliated against for filing a complaint.**

I have read the Privacy Notice and understand my rights regarding my Personal Health Information (PHI) and health care records and how this information will be used, as presented in the Privacy Notice.

I consent to the use and disclosure of my PHI/Records for purposes of treatment, payment, or other health care operations. I understand and agree to the legally imposed required disclosures and the stated office practices, which do not require my signature for disclosure.

Other uses of my PHI/Records will require a signed authorization from me for the specific intention of the disclosure.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

Client Signature (If over age 14) Date

_____ _____

Parent/Guardian/Legal Representative Signature* Date

*Relationship _____

_____ _____

Clinician, Leannah Farbotko, LCSW Date

CONFIDENTIALITY AND ITS LIMITS

This document is supplemental to (but not less important than) the Privacy Notice.

Note: All references to "you" or "your" as the client also apply to your minor child if they are the client.

As a general rule, I will not disclose the information obtained from your contacts with me, or the fact that you are my client, except with your written consent. However, there are some important exceptions to this confidentiality rule, as described below, or as otherwise specified by law. Some of these circumstances are what I determine to be best practice, whereas others are dictated by my professional ethics and/or are required by law.

It is my policy to provide information to others without your consent under certain circumstances:

1. Harm to self/others: If I believe that you are at imminent risk for harming yourself or someone else, I will disclose information to the extent needed for ensuring your safety and/or the safety of others.
2. Vacations/emergency coverage: My colleagues and I rotate emergency coverage. If they need information to assist you in my absence/unavailability, I will provide it without using your full name; feel free to discuss this with me in advance if you have any concerns.
3. Consultation and supervision: To ensure that I am providing quality care, I sometimes meet with outside consultants. In addition, my colleagues and I participate in ongoing peer supervision where we function as consultants to each other. In either case, I will not reveal identifying information; your first name, only, will be used during our discussions.
4. Collections and legal actions: If it is necessary to secure the services of an attorney or collection agency to collect fees, the personnel associated with those offices will have access to the necessary identifying information, including but not limited to your full name, address, and phone number.
5. Paper records/voice mail/fax: My office colleagues do not have access to your client record. Furthermore, we share an office voice-mail system that has private confidential voice mailboxes. My cell phone number is 571-556-8790 and is protected by password. However, our fax machine is shared, and faxed documents are potentially in the view of others in the office for a short period of time.
6. Email and electronic correspondence/storage: If you are willing, I can communicate with you by email/ text message. I personally open respond to all email and my account is secured by a private pass code.
7. Telephone call contact to you: When it is necessary to leave you a voicemail message on your telephone line, I will identify myself as Leannah Farbotko, and will leave a brief message. I will attempt to limit the voicemail information to the minimum amount required to respond to your question. If you prefer that I not proceed in this manner, please let me know.
8. Drug Treatment: If you are under 18, and it is determined that specialized drug/chemical dependency treatment is needed, I will need to communicate this to your parents. Drug abuse treatment is not a service that I am trained to provide to you.
9. Court Proceedings: While it is very unlikely, disclosure of your confidential information may be necessary to arrange for legal services to enforce or defend my legal rights.
10. National Security: Under certain circumstances, disclosure of your health information to authorized federal officials may be required for lawful intelligence, counterintelligence, and other national security activities.
11. HIPPA: Please read and sign separate HIPAA document.

Virginia law requires mental health providers to release information to others in certain circumstances: Virginia therapists are required by law to report certain information. This includes suspicion of abuse or neglect of a child or of an aged or incapacitated adult. This information must be reported to the Department of Social Services. Information that a licensed clinical social worker is engaging in unethical or illegal practices must be reported to the Board of Social Work. For individuals, who are licensed by a health regulatory board and who are receiving therapy, I am required to report the latter, if I believe that your condition places the public at risk.

In Virginia court cases, therapist-client privilege may not apply in certain cases, including the following: criminal cases, adult and domestic abuse, child abuse cases, any court case in which your mental health in an issue, and in

any case in which the judge "in the exercise of sound discretion, deems it necessary to the proper administration of justice." This means that information communicated to a therapist can be admitted as evidence in a court case against your wishes if a judge so rules. Others sometimes issue a subpoena seeking either treatment records for testimony from your present or former therapist as evidence in a court case, including child custody cases. If I receive such a subpoena, I will inform you immediately and, with your consent, will cooperate with your attorney in filing motions to quash the subpoena and requesting that the confidentiality of the therapy/assessment relationship be protected. However, only the judge may decide whether or not the requested information or records must be disclosed.

Virginia law allows certain others to request access to treatment records in specific circumstances. These include:

- Protective Services Workers to whom I have reported suspicion of abuse or neglect, if they so request.
- Court Appointed Special Advocates or Guardian Ad Litems (GAL) in child abuse or neglect proceedings, if the court so orders, and
- Evaluators involved in a minor's involuntary commitment to inpatient treatment if they so request.

In such cases, I will make every attempt to limit the information disclosed by substituting an oral or written report rather than submit actual treatment records.

Clients under age 16: If you are under 16, Virginia law allows your parents to obtain information and/or records related to your treatment. **Parents of clients who are under age 16**: In general, I ask that you transfer the right to privacy to your child; you will, however, be kept informed of the important goals of therapy and how you can be helpful. Any specifics that are important for you to know, I will encourage your child to discuss with you, with my help if necessary.

I understand that if I receive mental health services from Leannah Farbotko, LCSW the above limitations may be imposed on confidentiality. I hereby accept those limitations of confidentiality and consent to receive services under those conditions.

_____ _____

Client Signature (If over age 14) Date

_____ _____

Parent/Guardian/Legal Representative Signature* Date

*Relationship _____

_____ _____

Clinician, Leannah Farbotko, LCSW Date