

**ANDREW PRICE THERAPY, LLC**  
**NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS**

**CONFIDENTIALITY**

Generally speaking, the information provided by and to the client is legally confidential and cannot be discussed or released without the client's consent. There are exceptions to this confidentiality, which are listed in this HIPAA Notice of Privacy Rights, the Informed Consent, Treatment Disclosure & Contract for Services, as well as other exceptions in state and federal law. If a legal exception arises during therapy, if feasible, I will inform you accordingly. Exceptions include: suspected child abuse, molestation or incest, a client is in danger of hurting self or others, credible threats of violence, suspected abuse of the vulnerable adults, suspected threat to national security, and subpoenaed testimony in criminal court cases.

**CHILDREN AND ADOLESCENTS**

In my practice, children eighteen or younger must have the signature of a parent. In the case of divorce, the authorization must be signed by both parents or I must be provided a copy of a court document that establishes sole custody. As a parent or legal guardian of the named child, you have the right to information concerning your minor child in therapy, except where otherwise stated by law. Most provisions of this document apply to protected health information (PHI) of minor children.

**MY LEGAL DUTY**

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices. The Notice takes effect January 15th, 2018 and will remain in effect until replaced or updated.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

Your consent to receive treatment allows for your PHI to be used and/or disclosed for the following reasons. When so utilized, I will limit your information to the necessary minimum in order to achieve said activities. PHI is generally limited to name, address, date of birth, session date and start/stop time, the modalities and frequency of treatment provided, results of clinical tests, symptoms, treatment plans, prognosis, and progress to date. Your PHI does not include clinical details about our conversations or sessions. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." These are my clinical notes about our sessions. Any Psychotherapy Notes that I generate and record on any medium will be filed separately from the rest of your treatment records.

Healthcare Operations: I may use your or disclose your PHI to support my business activities as a private practice mental health provider. These activities may include, but are not limited to, quality reviews, cost management functions, clinical supervision, licensing, and credentialing.

Treatment: With your consent for treatment I may use or disclose your PHI to provide, coordinate, or manage your mental health services provided by my practice. This includes coordination of your healthcare with a third parties who already have your written permission to have access to your PHI.

Payment: I may use or disclose your PHI in order to obtain reimbursement for services, billing and collection activities, and credit card processing. Any vendors I utilize for such function are generally bound to the same privacy guidelines outlined in this notice. However, I cannot guarantee the status of your information and privacy once your PHI has been transmitted outside my office.

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I must disclose your PHI when required to do so by law or when ordered by a court having jurisdiction over an appropriate matter. I must disclose your PHI to appropriate authorities if I reasonably believe that you are a vulnerable adult or child who is victim of legally defined abuse, neglect, or the possible victim of certain other crimes. I will disclose only that PHI which I am legally required to do so in order to avert a serious threat to your health and safety to yourself or others. In the event of your incapacity or emergency circumstances, I will disclose only health information that is directly relevant to the person's involvement in your safety and healthcare, based on a determination using my professional judgment.

**ACCESS**

You have the right to inspect or obtain copies of your health information, except for Psychotherapy Notes and certain other limited exceptions. If you request copies, I charge \$.50 for each page to locate and copy your health information, and necessary postage. I will provide you copies by email or USPS mail only.

**NOTICE OF RIGHTS AND RESPONSIBILITIES**

Below is a description of your rights and your responsibilities with regard to your protected health information and treatment. To exercise these rights you must present an email or written request to me.

Right to Non-discrimination: You have the right to not be discriminated against on the basis of age, race, gender, ethnic origin, disabilities, religious affiliation, or sexual orientation.

Right to Professional Disclosure: You have the right to inquire about training, professional competencies, experience, education, and other relevant information that may be important to you in the provision of services. You have the right to confirm my credentials with the State of Maryland Board of Professional Counselors and Therapists.

Right to Professional Recommendations, Opinions, and Referrals: You have the right to be informed of the assessment of the presenting problem(s) and to know available treatment alternatives. You also have the right to understand the purpose of professional services, including an estimate of the number of therapy or consultation sessions, the expected length of time involved, the cost of services, the method of treatment, and the expected outcomes of therapy. You have the right to consent to or refuse recommended treatment. During the course of treatment, it may be determined that referrals for further or specialized services or consultations are appropriate. Referrals may be made for a number of reasons including need for educational services, psychological testing, medical and/or psychiatric evaluations, etc. Referrals will be provided and discussed openly with you. You have the right to an explanation of these referrals.

Right to Confidentiality and to Release/Restrict Disclosure of Health Care Information: You have the right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, and other persons identified by you. You have the right to receive summary of necessary confidential communications of your PHI from me to others. You also have the right to receive an accounting of disclosures of PHI uses outside of treatment, payment, and health care operations listed elsewhere in this document.

Right to Access and to Amend: You have the right to access, inspect, and copy your (or your child's) protected health information. You also have the right to request an amendment to your protected health information. I will be happy to discuss your requests for amendment and will make such amendments

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when I determine appropriate, based on my professional experience. However, I am not required to do so.

Right to Informed Consent and Notice of Privacy Practices: You have the right to obtain a paper copy of this notice from me upon request. I am required by law to maintain the privacy of your protected health information and to provide you with notice of my legal duties and privacy practices with respect to protected health information. I am required to abide by the terms of the Notice of Privacy Practices and Patient Rights and to make any future notices' provisions effective for any protected health information that I already maintain. Revisions to my Notice of Privacy Practices and Patient Rights will be posted on the effective date and you may request a written copy of the revised notice. You have the right to file a formal, written complaint with me at the address below, or with the Department of Health and Human Services, office of Civil Rights, in the event you feel your privacy rights have been violated. I will not retaliate against you for filing a complaint.

**For more information about my Privacy Practices, please contact:**

Andrew Price, MS, LGMFT  
240-745-5998

**For more information about HIPAA or to file a complaint, please contact:**

The U.S. Department of Health and Human Services  
Office of Civil Rights  
200 Independence Avenue SW  
Washington, DC 20201

*By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.*

\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client Name**