

**NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION and  
HIPAA Compliance**

[45 CFR 164.520; <http://www.hhs.gov/ocr/hipaa/guidelines/notice.pdf>]

**Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice of Privacy Practices describes how Change Relationships Inc., and its employees, independent contractors, volunteers, office and third-party contractors may use and disclose your protected health information (PHI) for purposes of treatment, payment and health care operations, and for other purposes that are permitted or required by law.

**I. RESPONSIBILITIES:**

The therapist at Change Relationships Inc., value your privacy and the privacy of your information. This office is required by law to maintain the privacy of your health information and provide you with this Notice of Privacy Practices. This office will abide by the terms of this Notice of Privacy Practices. We reserve the right to change this Notice of Privacy Practices and to make any new Notice of Privacy Practices effective for all protected health information that we maintain. Any new Notice of Privacy Practices adopted will be posted on this website and any breach of your privacy will be reported to you.

**II. WHAT IS "PROTECTED HEALTH INFORMATION" (PHI)?**

Protected health information ("PHI") is demographic and individually identifiable health information that will or may identify the client and relates to the client's past, present or future physical or mental health or condition and related health care services.

**III. WHAT DOES "HEALTH CARE OPERATIONS" INCLUDE?**

Health care operations include activities such as communications among health care providers, conducting quality assessment and improvement activities; making travel arrangements to and from this office; coordinating temporary housing; evaluating the qualifications, competence, and performance of health care professionals; training future health care professionals; contracting with insurance companies: conducting medical review and auditing services; compiling and analyzing information in anticipation of or for use in legal proceedings; and general administrative and business functions.

**IV. HOW IS MEDICAL INFORMATION USED?**

This office uses medical records as a way of recording health information, planning care and treatment as a tool for routine health care operations. You may request statements from this office to share with your insurance company, for possible reimbursement. You may request information such as procedure and diagnosis information that may be required to submit in order to possibly receive reimbursement for services. Other health care providers or health plans reviewing your records must follow the same confidentiality laws and rules required of this mental health office.

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Client records are also a valuable tool used by researchers in finding the best possible treatment for diseases and medical conditions. All mental health researchers must follow the same rules and laws that other health care providers are required to follow to ensure the privacy of client information. Information that may identify clients will not be released for research purposes to anyone outside of this office without written authorization from the client or the client's parent or legal guardian.

#### **V. EXAMPLES OF HOW MEDICAL INFORMATION MAY BE USED FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS**

- Medical information may be used to justify needed client care services, (i.e., lab tests, prescriptions, treatment protocols, research inclusion criteria).
- We will use medical information to establish a treatment plan.
- We may disclose protected health information to another provider for treatment (i.e. referring physicians, specialists and providers).
- We may submit claims to your insurance company containing medical information and we may contact their utilization review department to receive pre-certification (prior approval for treatment).
- We may use the emergency contact information you provided to contact you if the address of record is no longer accurate.
- We may contact you to remind you of the client's appointment by calling you or sending an email or text.
- We may contact you to discuss treatment alternatives or other health related benefits that may be of interest.
- We may use information for making travel arrangements to and from this mental health office.
- We may use information to coordinate temporary housing at such facilities as Ronald McDonald House, Target House, Our Lady's Inn, and / or local hotels.
- The client's name, home address, location, and dates of service.

#### **VI. WHY DO I HAVE TO SIGN A CONSENT FORM?**

When you, as the client or the parent or guardian of a client, sign a consent form, you are giving this office permission to use and disclose protected health information for the purposes of treatment, payment and health care operations. This permission does not include psychotherapy notes, psychosocial information, alcoholism and drug abuse treatment records and other privileged categories of information which require a separate authorization. You will need to sign a separate authorization to have protected health information released for any reason other than treatment, payment or healthcare operations.

#### **VII. WHAT ARE PSYCHOTHERAPY NOTES?**

Psychotherapy notes are notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session that are separated from the rest of the client's medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, modalities and frequencies of treatment furnished, results of office tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

#### **VIII. WHAT IS PSYCHOSOCIAL INFORMATION?**

Psychosocial information is information provided to your social worker regarding your family's social history and counseling services you have received.

#### **IX. WHY DO I HAVE TO SIGN A SEPARATE AUTHORIZATION FORM?**

In order to release client protected health information for any reason other than treatment, payment and health care operations, or as otherwise provided by law, we must have an authorization signed by the client, or the parent or guardian of the client, that clearly explains how they wish the information to be used and disclosed. The following are some examples of releases of information that require a separate authorization:

- Psychotherapy notes.
- Psychosocial information.
- The sharing of information and photographs for fundraising and public relations purposes.
- Use of information in scientific and educational publications, presentations and materials related to the work at this mental health office.
- The sharing of information with other office and scientific cooperative groups that this office collaborates with to further care through research, education and treatment.
- Uses and disclosures of psychotherapy notes or information for marketing purposes.
- Uses and disclosures of psychotherapy notes that would constitute a sale of psychotherapy protected information or other uses not described in this document.

#### **X. CAN I CHANGE MY MIND AND REVOKE AN AUTHORIZATION?**

You may change your mind and revoke an authorization, except (1) to the extent that we have relied on the authorization up to that point, (2) the information is needed to maintain the integrity of the research study, or (3) if the authorization was obtained as a condition of obtaining insurance coverage. All requests to revoke an authorization should be in writing.

#### **XI. SHARING INFORMATION WITH ASSOCIATES**

There are some services provided to this office through contracts with business associates. Examples include billing services, transcription services, etc.. When these services are contracted, we may disclose your health information to the business associate so that they can perform the job we have contracted them to do. To protect your health information, we contractually require our business associates to follow the same confidentiality laws required of this office.

#### **XII. WHEN IS MY AUTHORIZATION / CONSENT NOT REQUIRED?**

The law requires that some information may be disclosed without your authorization in the following circumstances:

- In case of an emergency
- When there are communication or language barriers
- When required by law
- When there are risks to public health
- To conduct health oversight activities
- To report suspected child abuse or neglect

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- To report SIDS
- To specified government regulatory agencies
- In connection with judicial or administrative proceedings
- For law enforcement purposes
- In the event of a serious threat to health or safety

### **XIII. YOUR PRIVACY RIGHTS**

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

#### **1. You have the right to inspect and copy your health information.**

This means you may inspect and obtain a copy of your PHI that is contained in a "designated record set" for so long as we maintain the PHI. A designated record set contains medical and billing records and any other records that this office uses in making decisions about your healthcare. You may not however, inspect or copy the following records: psychotherapy and psychosocial notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and certain PHI that is subject to laws that prohibit access to that PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have the right to have this decision reviewed. Please contact the HIPAA Privacy Officer if you have questions about access to your medical record.

#### **2. You have the right to request a restriction of your health information.**

This means you may ask us to restrict or limit the medical information we use or disclose for the purposes of treatment, payment or healthcare operations. Cindy Badamo, MSW, LCSW is not required to agree to a restriction that you may request. We will notify you if we deny your request. If we do agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting the HIPAA Privacy Officer.

#### **3. You have the right to request to receive confidential communications by alternative means or at alternative locations.**

We will accommodate reasonable requests. We may also condition this accommodation by asking you for an alternative address or other method of contact. We will not request an explanation from you as the basis for the request. Requests must be made in writing to the HIPAA Privacy Officer.

#### **4. You have the right to request amendments to your health information.**

This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with the HIPAA Privacy Office and we may prepare a rebuttal to your statement and will provide you with a copy of this rebuttal. If you wish to amend your PHI, please contact this office and/or the HIPAA Privacy Officer. Requests for amendment must be in writing.

#### **5. You have the right to receive an accounting of disclosures of your health information.**

You have the right to request an accounting of certain disclosures of your PHI made by this

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office. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for our Hospital Directory, to family or friends involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to this office or the HIPAA Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years.

**6. You have the right to receive a paper copy of this Notice of Privacy Practices and HIPAA Compliance.**

**XV. WHAT IF I HAVE A QUESTION / COMPLAINT?**

Please contact Cindy Badamo, MSW, LCSW, via the telephone provided to you and provide a written summary of your question or complaint. If you have additional questions or concerns please contact the HIPAA privacy officer for this region of Missouri within 180 days of the complaint:

Region VII  
Office for Civil Rights  
U.S. DHHS  
601 East 12<sup>th</sup> Street, Room 248  
Kansas City, MO 64106  
(816) 426-7277 Office  
(816) 426-7065 (TDD)  
(816) 426-3686 Fax

**HIPAA Compliance**

This document is a notice of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and prepared by Change Relationships Inc., to help you understand your privacy rights. You may also review the full and complete HIPAA document prior to signing any consent. This Notice of Privacy Practices and HIPAA Compliance is posted on my website, as legally required, and describes your privacy rights and how protected health information about you may be used by me and may be disclosed to others for the purpose of treatment, payment, health care operations, or for an appointment reminder. Signing consent forms will give you the right to request that I restrict how protected health information is used and disclosed for treatment, payment, health care operations, or appointment reminders. This restriction is binding.

There are circumstances where your information is used without your prior and express permission:

1. When I am required by law to involuntarily treat you;
2. For public health or safety issues;
3. As required by State, Federal, or local law; and,
4. For law enforcement.

Even in these instances, I will, if at all possible, keep you informed.

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You have the right to inspect records but this does not including psychotherapy notes or information compiled in anticipation of litigation. Psychotherapy notes are defined as detailed notes recorded by a mental health professional, documenting or analyzing the contents of conversations during a private, couples, family, or group counseling session. To inspect and/or copy mental/medical health records you must submit your request in writing to me, using a valid HIPAA release of information, which form I can provide to you upon request. Upon your written and valid request for medical records, I have 45 days (RSMo. Section 191.227) to provide such records and I will charge the legally allowed fee for such copies, or a \$25.00 administration fee plus \$.15/page (RSMo. Section 191.227).

I reserve the right to change the Notice of Privacy Practices, which is also posted on my website, and it is effective per the date on the top right-hand corner. Disclosure of your health information that is not covered in the Notice of Privacy Practices will not be made without your written authorization. If you provide me with written authorization to use or disclose information, you can change your mind and revoke your authorization at any time and only in writing. If you revoke your authorization, I will no longer use or disclose information about you; however, I will not be able to take back any disclosures made pursuant to your previous authorization. If you believe your privacy rights have been violated, you may report the problem to HIPAA on their website at [www.HIPAA.uab.edu](http://www.HIPAA.uab.edu).