PAHRUMP VALLEY COUNSELING

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. This is a "friendly" version. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protection to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, health insurance payers as is necessary and appropriate for your care. Patient files are stored in a locked filing cabinet. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and documents or information.
2. If requested, this office will remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. The vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies, CFT, Contract Supervisors or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of Ramona Sanchez, LCSW, LMFT/owner.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services without your specific prior written permission.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the client.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

By signing below, I do hereby consent and acknowledge my agreement to the terms set forth in this document and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Client Name:_____

_____ _____

Client/Parent/Legal Guardian Printed Name and Signature Date

_____ _____

Agency Representative Printed Name and Signature/Title Date