Pleshe Counseling Services, LLC
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NOTICE PRIVACY PRATICES AND PROCEDURES

In compliance with the Healthcare Insurance Portability and Accountability Act (HIPPA) which took effect in April 2003, I need to make you aware that all patient information is held in strict confidence and cannot be shared with any party without your written consent.

This office may disclose information only with your written consent to:

1. Your primary care physician or other professional involved in your care.
2. Your attorney, probation officer, or other professional involved in your treatment.
3. Any other party deemed necessary to provide quality health care.

This clinic may disclose information without your consent under the following circumstances:

1. You pose a serious threat to yourself or another person.
2. You are directly involved in child or senior abuse/neglect.
3. At the request of a judge or magistrate when court ordered to do so.
4. You have failed to provide payment for services or payment of insurance co-pays and/or deductibles per your treatment agreement within 90 days of the services and collection is necessary to secure payment.

You have a right to access your medical records; however, your therapist may deem direct access harmful to the therapeutic relationship and to your well-being. In some cases, a summary may be provided either verbally or in writing. You must make all requests for record access in writing and allow five (5) business days for a response. Your therapist is allowed 10-30 business days to provide a summary or documents reason for refusal. You also have a right to amend, your medical record under certain circumstances. If your therapist agrees that the amendment is necessary, your record will reflect these changes. If she disagrees, she will provide a justification in writing to you and then you have five (5) days to respond. The therapist will also keep an account of all disclosures made, with the exceptions noted above.

When written release of information forms are signed, you have the right to rescind this release at any time. This rescind request must be made in writing directly to your therapist.

It is our hope that here procedures with protect your rights and privacy. If you have any questions, please ask your therapist directly. You are entitled to a copy of these policies upon request. If there are further question, please write to: Department of Health and Human Services, 200 Independence Avenue, SE, Room 509F, HH Building, Washington, DC 20201

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____