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[www.bewellfamilycounseling.com](http://www.bewellfamilycounseling.com)

**HIPPA** [**Notice of Privacy Practices**](https://www.zoeriggs.com/s/HIPAA-NOTICE-OF-PRIVACY-PRACTICES.pdf)

The following information is provided to help you determine if what Be Well Family Counseling offer as a mental health professional meets your needs as a client. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Confidentiality**

You understand that the information that you share with your treatment provider will remain confidential in accordance with Oregon and Federal rules and law, [Including ORS 107.154, 179.505, 179.507, 192.515, 192.507, 414.679 and 42 CFR Part 2 and 45 CFR Part 205.50.] unless you provide written permission to release information. Exceptions to this are stated below:

* The receipt of information that suggests that there has been abuse or neglect of a child, elder or adult with a mental illness or disability. This includes a requirement to report intimate partner violence, sexual assault of an adult, and violence witnessed by a child under 18.
* The threat of harm to self or others. This may include warning a person threatened with harm, or disclosure of necessary health information to a person, agency or authority, who has the capacity to deal with the danger (law enforcement, hospitals, protective service agencies).
* Your information may be reviewed by your health plan, and if you are covered by OHP/Oregon Health Plan and Medicaid this may be including the Oregon Health Authority or the local coordinated care organization for authorizing services. Your information may also be reviewed for quality improvement, utilization management, and site review. With release of information or for coordination of treatment within a CCO (Community Care Organization) individuals providing physical health care may also review your information.
* For individuals covered by OHP/Oregon Health Plan and Medicaid, information, including HIV and other health and mental health diagnoses, may be shared within the coordinated care network for the purpose of providing whole-person care.
* In the event of a medical emergency, Be Well Family Counseling may release information. This is limited to that which is judged necessary to resolve the emergency and assist in your care by the attending emergency worker.
* In case of psychiatric hospitalization, information about your mental health status prior to entering the hospital, and information judged to be helpful in planning for your discharge from the hospital, may be released.
* Information may be released upon valid court order.
* If you file a legal claim or formal complaint or action against Be Well Family Counseling relating to services received.

 You have also been offered a copy of The Notice of Privacy Practices, which has been verbally explained to you.

By initialing you agree that you have read and understand this section.

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**Electronic Communication Policy**

Some clients have requested that we communicate with them via e-mail or text message. Information contained in e-mail and text messages isn’t guaranteed to remain confidential due to the limitations of the Internet and electronic media. Be Well Family Counseling may only use email or text for scheduling, re-scheduling, or cancellation and the communications should not contain information that would normally be part of the session. you understand that the electronic information that you share with your treatment provider, including copies or summaries of email and text messages, will be maintained in your file according to state regulations governing mental health records.

By initialing you agree that you have read and understand this section.

**Use and Disclosure of PHI for the Purposes of Providing Services**

Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow Be Well Family Counseling to use and disclose your health information for these purposes. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time with written notice.

Treatment Services: Be Well Family Counseling may use and disclose your PHI in order to provide, manage or coordinate my care. Be Well Family Counseling may also disclose your PHI in order to consult with another health care professional regarding your treatment or if Be Well Family Counseling is referring you to another health care professional.

Collecting Payment: Be Well Family Counseling may use and disclose your PHI in order to verify insurance and coverage, process claims and collect fees, whether from you, your insurance company or a third-party payer.

Appointment Reminders: Be Well Family Counseling may use your PHI in order to contact you regarding appointment reminders, rescheduling or cancellations.

By initialing you agree that you have read and understand this section.

**Your Rights Regarding Your PHI:**

You have the following rights regarding PHI I maintain about you. If you choose to exercise any of these rights, please do so in writing.

1. Right of Access To Inspect and Copy. You have the right, which may be restricted in certain circumstances, to inspect and copy PHI that I maintain. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence to suggest that access would cause serious harm to you. This may be the case with psychotherapy notes. I may charge a reasonable, cost, based fee for copies.

2. Right to Amend. If you feel the PHI I have about you is incorrect or incomplete, you may ask me in writing to amend the information although I am not required to agree to the amendment. You may write a statement of disagreement if your request is denied which will be maintained a part of your record and be included with any disclosure.

3. Right to an Accounting of Disclosures. You have the right to request a copy of the accounting of disclosures I have made of your PHI.

4. Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your requested restriction. If I do agree, I will maintain a written record of the agreed upon restriction.

5. Right to Request Confidential Communication. You have the right to request that I communicate with you in alternative ways or at an alternative location (e.g., via email). I will do my best to accommodate reasonable requests.

6. Right to a Copy of this Notice. You have the right to obtain a paper copy of this notice from me upon request.

7. Right of Complaint. Because I am the Contact Person of this practice, you may complain to me and to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights may have been violated. You may file a complaint with me by simply providing me in writing the specific manner in which you believe the violation occurred, the approximate date of such occurrence, and any details that you believe will be helpful to me. I will not retaliate against you in any way for filing a complaint with me or with the Secretary. Complaints to the Secretary must be filed in writing. A complaint to the Secretary can be sent to: U.S Department of Health and Human Services, 200 Independence Avenue, S.W. Washington, D.C. 20201. As the Privacy Officer of this practice, I have a duty to develop, implement and adopt clear privacy policies and procedures for my practice and I have done so. In general, client records, and information about clients, are treated as confidential in my practice and are released to no one without the written authorization of the client, except as indicated in this notice or except as may be otherwise permitted by law. Client records are kept secured so that they are not readily available to those who do not need them.

**If you need or desire further information related to this Notice or its contents, or if you have**

**any questions about this Notice or its contents, please feel free to contact me. I will do my**

**best to answer your questions and to provide you with additional information.**

**This notice first became effective on September 14, 2022.**

By signing this document, you are attesting that you have received, read, fully understood

and consent to the disclosures, terms and conditions above and have been given the

opportunity to ask questions.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_