Stacey Weber, M.A., LMHC
(WA #LH60746283)
2208 N.W. Market Street, Suite 504
Seattle, WA 98107
(206) 347-8559
Stacey@facethesea.com
www.facethesea.com

Privacy Practices Notice

This document describes how healthcare information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Purpose of this Document:
I am required to maintain the privacy of your health information. I am also required to provide you with this Notice about my privacy practices, legal obligations, and your rights concerning your Protected Health Information ("PHI"). This document will tell you about how I handle your PHI. It will detail how I use this information in my office, how I share it with other professionals and organizations, and how you may obtain access to it. If you ever have any questions pertaining to these privacy practices, please do not hesitate to discuss them with me. Additional copies of this Notice can be obtained through my website.

Your Protected Health Information:
Upon each visit, information is collected about your physical and mental health. This information may be concerning your past, present, or future health condition(s), the treatment or services rendered, and/or about payment for healthcare services. Any information I obtain from you will go into your physical medical record at my office and into the HIPAA compliant electronic software I use. This information will likely include:

- Your personal history;
- Reasons you came for treatment, including problems, symptoms, needs, and goals;
- Diagnoses: medical terms given to your symptoms;
- Treatment Plan, including treatment services, treatment goals, and outside work;
- Progress Notes;
- Records from other professionals who have treated or are currently treating you (if applicable);
- Psychological assessments, school records, parenting plans, and the like (if applicable);
- Information about any medications you have taken or are currently taking;
- Legal matters and documentation (if applicable);
- Billing and insurance information.

Uses and Disclosures of Your Protected Health Information (PHI):
When your information is read by me or others, it is known as "use." If the information is shared with others outside my office, it is called "disclosure." Whenever possible, I

will share only the minimum necessary PHI needed for the purpose. I hold confidentiality as an essential aspect of our work together. I will not disclose any information from our sessions, including the fact that you are or have ben a therapy client, without your prior written consent. If you provide such written consent, you maintain the right to revoke that consent at any time.
The law provides you the rights to know about your PHI, how it is used, and to have a say in how it is disclosed to others, with certain exceptions.

Permissible uses and disclosures without your written consent:

- When required to do so by law. Examples include the following:
  - When there is reason to suspect the occurrence of abuse or neglect of a child, a dependent adult, or a disabled person;
  - When there is a clear threat to do serious bodily harm to yourself or others;
  - In response to a subpoena issued by any governing body that is associated with a regulatory complaint;
  - Disclosures for public health activities;
  - Disclosures related to communicable diseases;
  - Health oversight activities including disclosures to state or federal agencies authorized to access PHI;
  - If you are involved in some legal action, it is possible a court order might require me to supply the court with evidence relating to your therapy;
  - Disclosures for research when approved by an institutional review board;
  - Disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions;
  - In the event of an emergency, emergency personnel or service providers may be given necessary information for treatment;
  - In the event of the client's death or disability, information may be released if the client's beneficiary of an insurance policy on the client's life signs a release authorizing disclosure;
  - In the event you reveal contemplation or commission or a crime or harmful act;
  - For auditing purposes or state licensing review or as otherwise authorized by law.

Your Rights as a Client under HIPAA:

- As a client, you have the right to inspect your file, unless it would endanger your health or another person's health or safety. *Psychotherapy notes are afforded special privacy protection under HIPAA regulations and are accordingly excluded from this right*. All requests for records must be made in writing.
- As a client, you may obtain a copy of your records or a summary of your treatment. There is a standard administrative fee for copies and a fee for a treatment summary may apply.
- As a client, you have the right to request amendments to your therapy file.

- As a client, you have the right to receive a history of all disclosures of protected health information. You will be required to pay any copying fees at $.20 a page as well as a fee for my time.
- As a client, you have the right to restrict the use and disclosure of your PHI for the purpose of treatment, payment, and operations. This includes providing information to your health insurance carrier for services paid out-of-pocket. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish to disclose.
- As a client, the following uses and disclosures of your PHI will be made only with your written authorization: 1) for marketing purposes, 2) any transaction that may constitute a sale of PHI, and 3) other uses and disclosures not described in this document.
- As a client, you have the right to register a formal complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

Prior to your therapy, you will receive a copy of these pages and my Professional Disclosure Statement. It will be necessary for you to sign these documents, indicating that you have read, received, and understood both documents. These documents will be placed in your file. If you do not fully understand any part of these documents, please discuss your questions with me and I will be happy to explain these documents further prior to you signing.

I acknowledge that I have received, read, and fully understand the above Notice of Privacy Practices. My signature below confirms that I understand and accept all the information contained in this document.

_____ _____

Client Name (Print) Date

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Stacey Weber, M.A., LMHC Date