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Notice of Privacy Practices

Health Insurance Portability and Accountability Act (HIPAA)

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

My goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to me. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires me to: (1) maintain the privacy of medical information provided to me; (2) provide notice of my legal duties and privacy practices; and (3) abide by the terms of the Notice of Privacy Practices currently in effect.

I. Uses and Disclosures for Treatment and Health Care Operations

Tina Schneider, Ph.D. may use or disclose your protected health information (PHI), for treatment and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

"PHI" refers to personal and identifiable health information about you in your health record.
"Treatment and Health Care Operations": Treatment is when I provide, coordinate or manage your health care and other services related to your healthcare. An example of treatment would be when I consult with another health care provider, such as your physician or another psychologist or therapist.
Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
"Use" applies only to activities within my office such as sharing, applying, utilizing, examining, and analyzing information that identifies you.
"Disclosure" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

We participate in an organized healthcare arrangement through OhioHealth Group, Ltd. (Health^4). Health^4 consists of an organized system of healthcare in which multiple covered entities participate. Through Health^4, we participate in joint activities that include utilization review, quality assessment and improvement activities, and certain payment activities. We may disclose your PHI to other participants in this organized healthcare arrangement in order to facilitate the healthcare operations activities of Health^4.

II. Uses and Disclosures Requiring Authorization

Tina Schneider, Ph.D. may use or disclose PHI for purposes outside of treatment, payment, and health care operations with your appropriate authorization. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. If I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information. You may revoke all such authorizations at any time, provided each

revocation is in writing. You may not revoke an authorization to the extent that we have relied on that authorization.

III. Uses and Disclosures with Neither Consent nor Authorization

The law provides that Tina Schneider, Ph.D. may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If, in my professional capacity, I know or suspect that a child under18 years of age or a child with mental retardation, a child who is developmentally disabled, or a child with physical impairments, under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, I am required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or a municipal or county peace officer.

Adult and Domestic Abuse: If I have reasonable cause to believe that an adult is being abused, neglected, or exploited, who resides in Ohio, and is unable to provide for his or her own care and protection because of the infirmities of aging or physical or mental impairment, I am required by law to immediately report such belief to the County Department of Job and Family Services.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release this information without written authorization from you or your legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: If I believe you pose a clear and substantial risk of imminent serious harm to yourself or another person, I may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to me an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and I believe you have the intent and ability to carry out the threat, then I am required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).

For payment: I may use your information to bill you, your insurance, or others, so I can be paid for the treatments I provide to you. I may contact your insurance company to find out exactly what your insurance covers. I may have to tell them about your diagnoses, what treatments you have received, and the changes I expect in your conditions. I will need to tell them about when we met, your progress, and other similar things.

I bill under Beth Rosner, Ph.D. LLC, as part of a group practice, so this name is what you might see on claims, with your insurance company.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are a client here. Upon your request, I will send any communications to an alternate address).

Right to Inspect and Copy: You have the right to both inspect and obtain a copy of your protected health information (i.e., your case file). At your request, I will discuss with you the details of the request process. If you want copies of your PHI, a charge for copying may be imposed, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy: You have the right to obtain a paper copy of this notice and/or electronic copy by email upon request.

Psychologist's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will notify you in writing, if I have your current address, and provide a written copy of my revised policies and procedures either in person, by mail, or by email. You may request a copy of my current policy at any time.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may discuss the situation with me free of charge. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I will provide

you with the appropriate address upon request.

VI. Effective Date

This notice will go into effect on March 1, 2019. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or email.

OHIO NOTICE OF PSYCHOLOGISTS' POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

SIGNATURE SHEET

I have received, understand, and agree to the provisions of a copy of the Notice of Privacy Practice for Tina Schneider, Ph.D.

_____	_____
Client Name	Date of Birth

_____	_____	_____
Signature of Client, Parent, or Guardian	Relationship	Date

Updated 03/25/2019