

2024 NOTICE OF PRIVACY AND PRACTICES

HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA)

This document is the *2024 Notice of Privacy and Practices Health Insurance Portability Accountability Act (HIPAA)*. It contains important information about federal law and the Health Insurance Portability and Accountability Act (HIPAA), which provides privacy protections and client rights regarding using and disclosing your Protected Health Information (PHI) used for treatment, payment, and healthcare operations. The HIPAA privacy rule applies to any medium-paper, electronic, or verbal PHI. The notice explains HIPAA and its application to your PHI in greater detail. Feel free to contact your provider if you have any questions.

"I," "WE," "US," AND "YOU"

For this *2024 Notice of Privacy and Practices Health Insurance Portability Accountability Act (HIPAA)* and other documents related to therapy services, "I" refers to Dennise A. Hall, a licensed professional counselor (the provider). "You" refers to a prospective, current, or past client who received therapy services from the provider at Health in Mind Counseling, PLLC (the private practice). "We" and "us" refer to the collective body of the provider, the private practice, contractors, and covered entities operating within the services of the private practice.

*Disclaimer: In this profession, we may use the terms 'patient' and 'client' interchangeably; 'counseling' and 'therapy' are also used interchangeably. Additionally, the terms 'provider,' 'therapist,' 'licensed professional counselor,' and 'clinician' may refer to the same role.

PROTECTED HEALTH INFORMATION (PHI)

Protected Health Information (PHI) means individually identifiable health information that is:

- Transmitted by electronic media
- Maintained electronic media
- Transmitted or maintained in any other form or medium.

INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Individually identifiable health information identifies or leads to an individual's identity. It is a subset of health information, including demographic information collected from an individual; information created or received by a health care provider, health plan, employer, or health care clearinghouse; and information related to past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payments.

For more information about the HIPAA Privacy Rule and the Notice requirements, see <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/notice.html>.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all client and provider communication. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets specific legal requirements imposed by HIPAA. Sometimes, I am required to disclose information without your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

- If you are involved in a court proceeding, and a request is made for information concerning your diagnosis and treatment, the provider-client privilege law protects such information. I can only provide information with your (or your legal representative's) written authorization or court order or if I receive a

subpoena of which you have been appropriately notified and have yet to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, consult with an attorney to determine whether a court would likely order me to disclose information.

- If a government agency requests the information for health oversight activities, I may be required to provide it for them within its appropriate legal authority.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client to defend myself.
- Suppose a client files a worker's compensation claim, and I provide the necessary treatment related to that claim. Upon appropriate request, I must submit treatment reports to the appropriate parties, including the client's employer, insurance carrier, or an authorized qualified rehabilitation provider.
- I may disclose the minimum necessary health information to my business associates who perform functions on our behalf or provide us with services if the information is required for such operations or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
- I may disclose the minimum necessary to Coroners and Funeral Directors to perform their legally authorized duties.

EXCEPTIONS TO CONFIDENTIALITY

There are some situations in which I am legally obligated to take actions necessary to protect you and others from harm. I may have to reveal some information about a client's treatment:

- If I know or have reason to suspect that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Texas Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
- If I know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the adult protective services. Once such a report is filed, I may be required to provide additional information.
- Suppose I believe there is a clear and immediate probability of physical harm to the client, other individuals, or society. In that case, I may be required to disclose information to take protective action, including communicating the information to the potential victim and appropriate family member and the police or to seek hospitalization of the client.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- For Treatment – I will use and disclose your health information internally during your treatment. If I wish to provide information outside our practice for your treatment by another healthcare provider, I will have you sign an authorization to release the information. Furthermore, consent is required for most disclosures to outside parties.
- For Payment – I may use and disclose your health information to obtain payment for your services as delineated in the *2024 INFORMED CONSENT* document.
- For Operations – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to ensure quality. I may also use your information to tell you about services, educational activities, and programs that interest you best.

CLIENT RIGHTS

- Right to Treatment – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- Right to Confidentiality – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for

payment or our operations with your health insurer. I will agree unless a law requires us to share that information.

- Right to Request Restrictions – You have the right to request restrictions on specific uses and disclosures of protected health information about you. However, I am not required to agree to the condition 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.
- Right to Inspect and Copy – You have the right to inspect or obtain a PHI copy (or both). Records must be requested in writing, subject to the provider's review, and authorized by the signed and completed form by the client. Furthermore, a copying fee applies for the personal use of records; see the *2024 Informed Consent* document for associated costs.
*If I refuse your request for access to your records, you have a right to object, which I will discuss with you upon request.
- Right to Amend—If you believe the information in your records is incorrect and/or missing important information, you can ask us to make specific changes, also known as amending, to your health information. You must make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if I will amend them. If I refuse, I will tell you why within 60 days.
- Right to a Copy of This Notice –You will receive the paperwork electronically and have a copy in your client portal, which is accessible from the website: <https://www.therapyportal.com/p/healthmind79934/>.
- Right to an Accounting – You generally have the right to receive an accounting of PHI disclosures regarding you. At your request, I will discuss the details of the accounting process with you.
- Right to Choose Someone to Act for You – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will ensure the person has this authority and can act for you before I act.
- Right to Choose – You have the right to decide not to receive services from me. If you wish, I will provide you with the names or agencies of other qualified professionals.
- Right to Terminate—You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. Please discuss your decision with me in session before terminating, or contact me by phone to let me know you are terminating services.
- Right to Release Information with Written Consent – With your written consent, any part of your record can be released to any person or agency you designate. We will discuss whether I think releasing the information in question to that person or agency might harm you.
- Right to Revoke Your Authorization - You may revoke Your Authorization, Your Marketing Authorization, or any written authorization obtained in connection with your PHI, except to the extent that the Facility and Health Professionals have acted in reliance upon it by delivering a written revocation statement via email (potential risk exist) or by mail (potential risk exist):

Main Office Number: (915) 248-4453

Fax: (915)206-4035

Email: info@healthinmindcounseling.org

Mail:

REGISTERED AGENTS, INC
C/O HEALTH IN MIND COUNSELING, PLLC
5900 BALCONES DRIVE, SUITE 100
AUSTIN, TEXAS, 78731

PROVIDER'S RESPONSIBILITIES

I am required by law to maintain PHI's privacy and provide you with a notice of my legal duties and privacy practices concerning PHI. I reserve the right to change the privacy policies and practices described in this notice. However, I must abide by the current terms unless I notify you of such changes. If I revise my policies and procedures, I will upload the revised notice in the client portal and prompt you to confirm receipt (via the client portal: <https://www.therapyportal.com/p/healthmind79934/>). I will answer any questions or concerns during the session.

SAFEGUARDS I TAKE TO PROTECT YOUR SECURITY AND PRIVACY

- I use secure passwords and 2-step verification for all platforms.
- I use HIPAA-secure technology for record-keeping and storage, communication, video, conferencing, computer encryption, and malware protection.
- I complete training on HIPAA compliance, cybersecurity, and risk management.
- I obtain the Business Associate Agreement required by HIPAA law from any company or professional individual who has access to your PHI.
- I use HIPAA-compliant services, HIPAA-compliant phone service, and a secure texting app for acceptable text communication [see *2024 INFORMED CONSENT* document].
- I do not record video sessions. I recommend that clients request recordings only after careful thought and discussion with the provider to determine possible clinical benefits. Because the security risks of recording sessions outweigh the potential therapeutic benefits in most cases, I advise against recording video sessions. Termination will follow if sessions are recorded without consent.
- I record audio and video in the waiting area to monitor who enters the office, help identify threats, and record footage of any possible incidents. Only authorized personnel will have access to the recorded footage. Authorized personnel will include the provider, any representative relevant to the private practice, and any law enforcement conducting investigations.
- I follow the American Psychological Association (APA) and the American Counseling Association (ACA) codes of ethics.

I have appointed two professional executors aware of the protocol in case of my incapacitation or death. The professional executor(s) will take control of the records and the active contact list. The professional executor will contact the client and provide information about a referral source for continued mental health services with another agency. The professional executor will keep records by law and ethical responsibilities.

HOW YOU CAN PROTECT YOUR SECURITY AND PRIVACY

- Store your login information in a place no one knows about.
- Use multi-factor authentication wherever possible.
- Do not share your login information, passphrases, and passwords.
- Remember that you are responsible for maintaining security on your electronic devices. Do not allow others access to your devices. A good rule of thumb is that if you do not give someone access to your wallet or bank account, you should not provide them with access to your electronic devices.
- Receiving links to your counseling sessions, therapy, training website, and documents containing PHI can constitute a risk to your privacy and security if someone in your household or workplace has access to your unsecured email. I recommend HIPAA-secure email, which makes it difficult for anyone but you to view your counseling emails. It is a bit extra work because you must enter a password to read encrypted emails, but that one additional step is worth protecting your peace of mind.
- Ensure no one else is in the room when you participate in video sessions with me.
- Do not make video or audio recordings of your counseling sessions or learning content. Doing so violates your service agreement and may violate state law. Violating this policy will result in the termination of the therapeutic relationship and may have legal and financial penalties.

- Do not take screenshots of your counseling sessions or records. Storing screenshots on a device or cloud that is not HIPAA-secure will compromise your confidentiality, privacy, and security.
- Do not take screenshots or video recordings of the therapy and training website or learning materials. Doing so is a copyright violation and can result in legal and financial penalties.
- Do not bookmark your private counseling website. If someone else accesses your computer, tablet, or phone and you are signed into a bookmarked site, other members of your household or workplace may be able to access your PHI.

COMPLAINTS

If you are concerned that I have engaged in improper or unethical behavior, you can talk to me or file a complaint with the licensing board that issued the provider's license or the US Department of Health and Human Services.

To file a complaint with me, you may call (915)248-4453, by letter to Registered Agents, Inc., C/O Health in Mind Counseling, PLLC, 5900 Balcones Drive, Suite 100, Austin, Texas, 78731.

To file a complaint with the Texas Behavioral Health Executive Council, call the investigations/ Complaints 24-hour, toll-free system at (800) 821-3205.

To file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, DC 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

This Practice will not retaliate against you for filing a complaint.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion before signing this document. You will also sign an agreement with us when you sign this document. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have acted in reliance on it.

Right to Change Terms of this Notice—The terms of this notice may be changed at any time. If this notice is changed, the new notice terms may be made effective for all PHI that the Facility and Health Professionals maintain, including any information created or received prior to issuing further notice. You may also obtain any new notice by requesting it with the provider in session or contacting the main office number (915) 248-4453.

Est. 2022

YOUR SIGNATURE BELOW INDICATES YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. ALSO, IT SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THIS "NOTICE OF PRIVACY AND PRACTICES & HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA)" DOCUMENT. YOU ACKNOWLEDGE THAT YOU ARE THE CLIENT OR THE CLIENT'S LEGAL REPRESENTATIVE AND AGREE THAT YOUR DRAWN OR GENERATED SIGNATURE IS A LEGALLY BINDING EQUIVALENT TO YOUR HANDWRITTEN SIGNATURE.