Renovate Mental

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HIPAA & Notice of Privacy Practices

Renovate Mental, LLC is committed to maintaining and protecting the confidentiality of the individual's PHI. **Renovate Mental, LLC** is required by federal and state law, including the Health Insurance Portability and Accountability Act ("HIPAA"), to protect the individual's PHI and other personal information. **Renovate Mental, LLC** is required to provide the individual with this Notice of Privacy Practices regarding their specific policies, safeguards, and practices. When **Renovate Mental, LLC** uses or discloses an individual's PHI, **Renovate Mental, LLC** is bound by the terms of this Notice of Privacy Practices, or the revised notice of Privacy Practices, if applicable.

I. My Pledge Regarding Your Personal Health Information:

- I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:
  - Make sure that protected health information ("PHI") that identifies you is kept private.
  - Give you this notice of my legal duties and privacy practices with respect to health information.
  - Follow the terms of the notice that is currently in effect.
  - I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. How I May Use and Disclose Your Health Information:

The following describes the ways **Renovate Mental, LLC** may use and disclose PHI. Except for the purposes described below, **Renovate Mental, LLC** will use and disclose PHI only with the individual's written permission. The individual may revoke such permission at any time by writing to **Renovate Mental, LLC** ATT: Compliance Officer

- **For Treatment:** We may use and disclose PHI for the individual's services. For example, **Renovate Mental, LLC** may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside **Renovate Mental, LLC**, who are involved in the individual's medical care and need the information to provide the individual with medical care.
- **For Payment:** We may use and disclose PHI so that or others may bill and receive payment from the individual, an insurance company or third party for the treatment and services the individual received. For example, we may tell the individual's insurance company about a treatment the individual is going to receive to determine whether the individual's insurance company will cover the treatment.
- **For Health Care Operations:** We may use and disclose PHI for health care operation purposes. The

uses and disclosures are necessary to make sure that all **Renovate Mental, LLC** patients receive quality care and to operate and manage our office.

- **Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services:** We may use and disclose PHI to contact the individual to remind them that they have an appointment with **Renovate Mental, LLC**. We also may use and disclose PHI to tell the individual about treatment alternatives or health-related benefits and services that may be of interest to the individual.
- **Research:** Under certain circumstances, **Renovate Mental, LLC** may use and disclose PHI for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. **Renovate Mental, LLC** will ask for the individual's written authorization before using the individual's PHI or sharing it with others to conduct research. Under no circumstances will we use and disclose PHI for research purposes without the individual's permission.
- **Incidental Use and Disclosure:** We are not required to eliminate every risk of an incidental use or disclosure of your PHI. Specifically, a use or disclosure of your PHI that occurs as a result of, or incident to an otherwise permitted use or disclosure is permitted as long as I have adopted reasonable safeguards to protect your PHI, and the information being shared was limited to the minimum necessary.

III. Special Situations in Which I May Disclose PHI Without Your Consent:

- **As Required by Law:** We will disclose PHI when required to do so by international, federal, state, or local law.
    - **To Avert a Serious Threat to Health or Safety:** We may use and disclose PHI when necessary to prevent a serious threat to the individual's health and safety or the health and safety of others. Disclosures, however, will be made only to someone who may be able to help prevent or respond to the threat, such a law enforcement or potential victim. For example, we may need to disclose information to law enforcement when a patient reveals participation in a violent crime.
    - **Law Enforcement:** We may release PHI if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, **Renovate Mental, LLC** is unable to obtain the individual's agreement; (4) about a death **Renovate Mental, LLC** believes may be the result of criminal conduct; (5) about criminal conduct on **Renovate Mental, LLC** premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.
    - **Abuse or Neglect:** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect. However, the information we disclose is limited to only that information which is necessary to make the required mandated report.
    - **Essential Government Functions:** We may be required to disclose your PHI for certain essential government functions. Such functions include but are not limited to: assuring proper execution of a military mission, conducting intelligence and national security activities that are authorized by law, providing protective services to the President, making medical suitability determinations for U.S. State Department employees, protecting the health and safety of inmates or employees in a correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs.
- **Business Associates:** We may disclose PHI to any business associates that perform functions on our behalf or provide **Renovate Mental, LLC** with services if the information is necessary for such functions or services. All of **Renovate Mental, LLC** business associates are obligated to protect the

privacy of the individual's information and are not allowed to use or disclose any information other than as specified in our contract.

- **Lawsuits and Disputes**: If the individual is involved in a lawsuit or a dispute, **Renovate Mental, LLC** may disclose PHI in response to a court or administrative order. **Renovate Mental, LLC** also may disclose PHI in response to a subpoena, discovery request, or other lawful request by someone else involved in the request or to allow the individual to obtain an order protecting the information requested.
- **Health Oversight**: I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors) and peer review organizations performing utilization and quality control. If we disclose PHI to a health oversight agency, we will have an agreement in place that requires the agency to safeguard the privacy of your information.
- **Psychiatry Notes**: If kept as separate records, we must obtain your authorization to use or disclose psychiatry notes with the following exceptions. We may use the notes for your treatment. We may also use or disclose, without your authorization, the psychiatry notes for my own training, to defend myself in legal or administrative proceedings initiated by you, as required by the **APPLICABLE STATE AGENCY** or the US Department of Health and Human Services to investigate or determine my compliance with applicable regulations, to avert a serious and imminent threat to public health or safety, to a health oversight agency for lawful oversight, for the lawful activities of a coroner or medical examiner or as otherwise required by law.

IV. You Have the Following Rights with Respect to Your PHI:

- **The Right to Request Limits on Uses and Disclosures of Your PHI**: You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
- **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full:** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
- **The Right to Choose How I Send PHI to You**: You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
- **The Right to See and Get Copies of Your PHI:** Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within **APPLICABLE TIME FRAME (CHECK STATE/FEDERAL LAWS)** of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.
- **The Right to Get a List of the Disclosures I Have Made:** You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within **APPLICABLE TIME FRAME (CHECK STATE/FEDERAL LAWS)** of receiving your request. The list I will give you will include disclosures made in **APPLICABLE TIME FRAME (CHECK STATE/FEDERAL LAWS)** unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.
- **The Right to Correct or Update Your PHI:** If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct

the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within APPLICABLE TIME FRAME (CHECK STATE/FEDERAL LAWS).

- **The Right to Get a Paper or Electronic Copy of this Notice:** You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it. (This notice will be available in your client portal).
- **Right to Get Notice of a Breach: Renovate Mental, LLC** is committed to safeguarding the individual's PHI. If a breach of the individual's PHI occurs **Renovate Mental, LLC** will notify the individual in accordance with state and federal law.
- **Right to Request Restrictions:** Individuals have the right to request a restriction or limitation on the PHI **Renovate Mental, LLC** uses or disclose for treatment, payment, or health care operations. Individuals also have the right to request a limit on the PHI we disclose to someone involved in the individual's care or the payment for the individual's care, like a family member or friend.
    - To request a restriction, the individual must make their request, in writing, to the Department in which their care was provided. **Renovate Mental, LLC** is not required to agree to the individual's request unless the individual is asking us to restrict the use and disclosure of the individual's PHI to a health plan for payment or health care operation purposes and such information the individual wishes to restrict pertains solely to a health care item or service for which the individual has paid Mindful Way Out-of-pocket in full. If we agree, we will comply with the individual's request unless the information is needed to provide the individual with emergency treatment or to comply with law. If we do not agree, we will provide an explanation in writing.
- **Out-of-Pocket Payments:** If the individual pays out-of-pocket (or in other words, the individual has requested that **Renovate Mental, LLC** not bill the individual's health plan) in full for a specific item or service, the individual has the right to ask that the individual's PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Acknowledgment of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

If you are a parent or guardian, please state your child's name here:

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_____ _____

Client Signature Date

_____ _____

Provider Signature Date