Gina LaRose, LPC, LLC
Notice of Privacy Practices

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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, rights to understand and control how your health information is used. We are required to abide by the terms of this notice. HIPAA provides penalties for misuse of personal health information.

HIPAA COMPLIANT USES AND DISCLOSURES:

• Providing, Coordinating, or Managing Your Treatment: For example, details of your treatment may be shared with another mental health professional during state mandated case review.
• Billing for Services and Collecting Payments: For example, personal health information may be shared with your insurance company when attempting to collect payment for services that have been rendered.
• Health Care Operations: Your information may be shared with other professionals involved in running our practices, for example, staff members.
• Other Allowable Disclosures Not Requiring Your Consent: Reporting child abuse or neglect, complying with a court order or subpoena, state mandated disclosure of deceased patients, medical emergencies that may necessitate disclosure to prevent serious harm, disclosure to legally authorized overseeing agencies for audits, investigations, or inspections, disclosure to authorized officials in government for national security and intelligence reasons, disclosure to legally authorized public health officials for the purpose of preventing and controlling disease and disclosure to prevent a serious imminent threat to the health or safety of a person or the public. Any other disclosures will be made only with your written authorization via our Release of Information form. You may revoke such authorizations in writing and we are required to honor and abide by that written request. If a breach of privacy occurs, you will be notified in writing.

I MAY CONTACT YOU TO:

• Provide you with appointment information or information about your treatment.
• Provide you with information about treatment alternatives or services that may be of interest to you.
• Collect payment for services that were provided.

YOUR INDIVIDUAL RIGHTS:

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. If we agree to a restriction, we must abide by it unless you submit a written request to remove it.
• You have the right to have disclosures of psychotherapy notes as well as sale of your information or marketing disclosures only on the basis of an authorization signed by you, the patient.
• The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
• The right to inspect a copy of your protected health information.
• The right to request that your file must be amended if you believe information is incorrect or missing. This request must be made in writing.
• The right to receive an accounting of your disclosed protected health information.
• The right to restrict disclosures of your information for services of which you have self-paid.
• The right to obtain an additional copy of this notice upon request.

I reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions immediately effective for all protected health information that we maintain. I will post any amendments to this notice and you may request a written copy of any revisions from our office at any time.
If you feel that your privacy protections have been violated you have the right to file a written complaint with my office or with the LA LPC Board.

Client Bill of Rights

All clients have the following rights:

- The right to be treated with dignity and respect, free from any verbal, physical, emotional or sexual abuse.
- The right to expect prompt, competent, and professional assessment and treatment services.
- The right to be treated fairly regardless of race, national origin, sex, age, religion, disability, or sexual orientation.
- The right to not be filmed, taped or photographed unless you agree to it.
- The right to receive prompt and adequate treatment.
- The right to participate in the planning of your treatment and care.
- The right to be informed of your treatment and care, including alternatives to and possible side effects of treatment, including medications.
- The right to receive treatment on a voluntary basis prior (except in emergencies) to being transferred to a more restrictive facility.
- The right to not participate in experimental research without your written informed consent.
- The right to be informed, in writing, or any costs of your care and treatment for which you or your relatives may have to pay.
- The right to be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding.
- The right to have treatment information kept confidential (unless the law permits disclosure or you sign a release).
- The right to ask to view your records.

If you feel your rights have been violated, you may use the following grievance procedure:
Discuss any concerns you have. However, you do not have to do this before filing a formal grievance with your service provider. As with any legitimate grievance or perceived violation of your rights, you have access to parish and state agencies, licensing boards, professional organizations and the courts for legal action if these procedures prove unsatisfactory to you.

Notice of Privacy Practices
Acknowledgment of Notice

Patient/Client Name:_____ **DOB**: _____

I hereby acknowledge that I have been given an opportunity to read a copy of Gina Larose, LPC, LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Gina LaRose at 4833 Conti St., Suite 202. New Orleans, LA 70119.

_____

Signature of Patient/Client **Date**

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative **Date**

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

□ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member **Date**