Eating and Behavioral Health Associates, LLC
4041 N. High St, Suite 300D
Columbus, OH 43214
614.431.1418

Notice of Privacy Practices

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.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

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

"PHI" refers to information in your health record that could identify you.

"Treatment, Payment and Health Care Operations" is when your doctor provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when your doctor consults with another health care provider, such as your family physician or another psychologist.

"Payment" is when your doctor obtains reimbursement for your healthcare. Examples of payment are when he/ she discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

"Health Care Operations" are activities that relate to the performance and operation of our 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 the Eating and Behavioral Health Associates (EBHA), LLC Practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside EBHA, LLC, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

EBHA, LLC may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when your doctor is asked for information for purposes outside of treatment, payment and health care operations, he/she will obtain an authorization from you before releasing this information. EBHA, LLC will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes your doctor has made about our conversation during a private, group, joint, or family counseling session, which are have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) your doctor has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

Your doctor may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If, in your doctor's professional capacity, he/she knows or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child 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, he/she is 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 your doctor has reasonable cause to believe that an adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, he/she is 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 your doctor will not release this information without written authorization from you or your persona or 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 your doctor believes that you pose a clear and substantial risk of imminent serious harm to yourself or another person, he/she 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 your doctor an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and your doctor believes you have the intent and ability to carry out the threat, then he/she is 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 the identity of the potential victim(s).

- Worker's Compensation: If you file a worker's compensation claim, your doctor may be required to give your mental health information to relevant parties and officials.

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, your doctor is 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 seeing a therapist. Upon your request, your doctor will send your bills to another address.)

- Right to Inspect and Copy - You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in your doctor's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your doctor may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, your doctor will discuss with you the details of the request process.

- Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your doctor may deny your request. On your request, he/she 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, your doctor 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 the notice from your doctor upon request, even if you have agreed to receive the notice electronically

Psychologist's Duties:

Your doctor is required by law to maintain the privacy of PHI and to provide you with a notice of his/her legal duties and privacy practices with respect to PHI. Your doctor reserves the right to change the privacy policies and practices described in this notice. Unless your doctor notifies you of such changes, however, he/she is required to abide by the terms currently in effect. If your doctor revises his/her policies and procedures, your he/she will notify you of such changes by posting notice in the office reception area, or by mail, if you are an inactive patient.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision your doctor made about access to your records, or have other concerns about your privacy rights, you may contact Dr. Sarah Altman at 614.431.1418.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. Your doctor will not retaliate against you for exercising your right to file a complaint.

VI. *Effective Date, Restrictions and Changes to Privacy Policy*

EBHA, LLC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that it maintains. EBHA, LLC will provide you with a revised notice by posting in the office.

Ohio Notice Form Contract

I have read and had an opportunity to ask questions about the attached Notice Form on the Policies and Practices to Protect the Privacy of My Health Information.

My signature below acknowledges my understanding and agreement with this document including that:

1. I give my consent to Eating and Behavioral Health Associates, LLC to use and disclose my protected health information (PHI) for treatment, payment, and health care operations purposes.
2. I may sign an Authorization Form to release my records to others as desired.
3. My PHI may be released without authorization in cases of suspected abuse or threat to safety, by Court order, or Worker's Compensation claim.

_____ _____

Patient Signature Date

_____

Printed Name

☐ Copy of Notice of Privacy Policy accepted by patient

☐ Copy of Notice of Privacy Policy refused by patient and kept by Dr. Altman