Austin Counseling Specialists LLC
4131 Spicewood Springs Rd. Suite M-1
Austin, TX 78759
Phone: (512) 814-6027 or Fax: (512) 666-3792

Confidentiality

Your privacy is protected by the Health Insurance Portability and Accountability Act (HIPAA)

NOTICE OF PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION 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.

Summary

This Notice describes how your personal health information (PHI) is protected, and how Austin Counseling Specialists LLC may use and disclose this information. PHI includes personally identifiable information that relates to your past, present, or future health, treatment, or payment for health care services. Austin Counseling Specialists LLC's employees and professional staff are required to comply with this privacy policy, and have access to this information only when there is an appropriate reason to do so, such as to confer with other health care providers or to submit claims for these services.

Under the Health Insurance Portability and Accountability Act (HIPAA), you are afforded privacy rights regarding the use and disclosure of your health information. These include:

· a right to be informed of the potential uses and disclosures of your protected health information, and to limit those uses and disclosures of this protected health information;

· a right to receive this written notice that explains how we may use and disclose your protected health information, your rights under HIPAA's privacy rule, Austin Counseling Specialists LLC's responsibilities as a covered entity under HIPAA;

· a right to a paper copy of this notice, or to have your legally designated representative receive a copy of this notice; you are asked to acknowledge receipt of this notice;

· a right to amend your record, to restrict what information from your record is disclosed to others, and to receive an accounting of disclosures of this information that were made without your authorization, other than for treatment, payment or health care operations;

· a right to have your complaints about our policies and procedures recorded in these records.

As a health care provider, Austin Counseling Specialists LLC is making a good faith effort to see that you or your representative have received and acknowledged this notice of privacy practices. If you are seen for emergency treatment, you will receive this notice as soon as practically possible afterward.

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

Austin Counseling Specialists LLC may use or disclose your protected health information (PHI), for certain treatment, payment, and health care operations purposes without your authorization. To help clarify these terms, here are some definitions:

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

· Treatment is when Austin Counseling Specialists LLC or another healthcare provider diagnoses or treats you. An example of treatment would be when Austin Counseling Specialists LLC consults with another health care provider, such as your family physician or another psychologist, regarding your treatment.

· Payment is when Austin Counseling Specialists LLC obtains reimbursement for your healthcare. Examples of payment are when Austin Counseling Specialists LLC discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

· Health Care Operations is when Austin Counseling Specialists LLC discloses your PHI to your health care service plan (for example your health insurer), or to your other health care providers contracting with your plan, for administering the plan, such as case management and care coordination.

· Use applies only to activities within Austin Counseling Specialists LLC's office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

· Disclosure applies to activities outside of Austin Counseling Specialists LLC's office, such as releasing, transferring, or providing access to information about you to other parties.

· Authorization means written permission for specific uses or disclosures. All authorizations to disclose must be on a specific, legally required form.

II. Uses and Disclosures Requiring Authorization

Austin Counseling Specialists LLC may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances when Austin Counseling Specialists LLC is asked for information for purposes outside of treatment and payment operations, Austin Counseling Specialists LLC will obtain an authorization from you before releasing this information.

You may revoke or modify all such authorizations of PHI at any time, provided each revocation is in writing; however, the revocation or modification is not effective until Austin Counseling Specialists LLC receives it. You may not revoke an authorization to the extent that (1) Austin Counseling Specialists LLC has relied on that information; 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

Austin Counseling Specialists LLC may use or disclose PHI without your consent or authorization in the following circumstances:

· Child Abuse: Whenever Austin Counseling Specialists LLC, in its professional capacity, has knowledge of or observes a child Austin Counseling Specialists LLC knows or reasonably suspects, has been the victim of child abuse or neglect, Austin Counseling Specialists LLC must immediately report such to a police department or sheriff's department, county probation department, or county or state welfare department.

· Adult and Domestic Abuse: If Austin Counseling Specialists LLC, in its professional capacity, has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if Austin Counseling Specialists LLC is told by an elder or dependent adult that he or she has experienced these, or if Austin Counseling Specialists LLC reasonably suspects such, she must report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency.

· Health Oversight: If a complaint is filed against Austin Counseling Specialists LLC with the State Board that licenses its profession, the Board has the authority to subpoena confidential mental health information from Austin Counseling Specialists LLC relevant to that complaint.

· Serious Threat to Health or Safety: If you communicate to Austin Counseling Specialists LLC a serious threat of physical violence against an identifiable victim, Austin Counseling Specialists LLC must make reasonable efforts to prevent harm, which may include communicating that information to the potential victim, and the police. If Austin Counseling Specialists LLC has reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, Austin Counseling Specialists LLC may release relevant information as necessary to prevent the threatened danger.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made about the professional services that Austin Counseling Specialists LLC has provided you, Austin Counseling Specialists LLC must not release your information without your written authorization or the authorization of your attorney or personal 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. Austin Counseling Specialists LLC will inform you in advance if this is the case.

IV. Patient's Rights and Provider'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, Austin Counseling Specialists LLC 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 Austin Counseling Specialists LLC and may request that she not telephone your residence).

· Right to Inspect and Copy You have the right to inspect or obtain a copy (or both) of PHI in Austin Counseling Specialists LLC's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Austin Counseling Specialists LLC may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, Austin Counseling Specialists LLC will discuss with you the details of the request and denial 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. Austin Counseling Specialists LLC may deny your request. On your request, Austin Counseling Specialists LLC 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, Austin Counseling Specialists LLC 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 Austin Counseling Specialists LLC upon request, even if you have agreed to receive the notice electronically.

Duties of Provider:

· Austin Counseling Specialists LLC is required by law to maintain the privacy of PHI and to provide you with a notice of her legal duties and privacy practices with respect to PHI.

· Austin Counseling Specialists LLC reserves the right to change the privacy policies and practices described in this notice. Unless Austin Counseling Specialists LLC notifies you of such changes, however, they are required to abide by the terms currently in effect.

· If Austin Counseling Specialists LLC revises its policies and procedures, Austin Counseling Specialists LLC will provide you with a written copy of the revised policies and procedures at the earliest possible opportunity following this revision, in person or by mail.

V. Informed Consent for Telehealth Services

Definition of Telehealth: Telehealth involves the use of electronic communications to enable Austin Counseling Specialists LLC mental health professionals to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, treatment, referral to resources, education, and the documentation of clinical information.

I understand that I have the following rights with respect to telehealth:

· The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

· I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care

or treatment.

· I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons.

· I understand that the use of telehealth at Austin Counseling Specialists LLC will initially be limited to an interim response to community concerns and closures related to the COVID-19 pandemic. Austin Counseling Specialists LLC will conduct ongoing assessment of these concerns and closures, with the goal of returning to seeing all clients for face to face counseling at the earliest reasonable time.

· In choosing to participate in telehealth, I am agreeing to participate using video conferencing technology.

· I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

· I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

· I understand that my express consent is required to forward my personally identifiable information to a third party.

· I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

· By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

· Please note that clients' session fees will remain the same as the fees currently agreed upon and are subject to the same policies regarding no-show and late cancellation. Insurance companies may be billed if participating in telehealth reimbursement, please consult a representative of your insurance provider regarding rate of reimbursement, number of sessions, who is eligible and any other questions that you may have specific to your insurance. We will provide you with a statement of service to submit to your insurance company if you wish.

By agreeing to telehealth services, the therapist and participant are agreeing to participate in a secure and confidential setting. In the event that a client is unable to sustain a confidential

environment for a telehealth session, the therapist may choose to remind the client of this requirement and will cease the session if confidentiality is not properly assured. A session will be rescheduled for another date with parameters for confidentiality begin re-explained.

VI. Complaints

If you are concerned that Austin Counseling Specialists LLC have violated your privacy rights, or you disagree with a decision Austin Counseling Specialists LLC made about access to your records, you may contact the Compliance Officer for further information.

For complaints, contact Austin Counseling Specialists LLC at (512) 814-6027, or:
Austin Counseling Specialists LLC
4131 Spicewood Springs Rd. Suite M-1 Austin, TX 78759
You may also send a written complaint to the Secretary of the Texas Behavioral Health Executive Council. Austin Counseling Specialists LLC will provide the appropriate address upon request.

VII. Effective Date, Restrictions, and Changes to Privacy Policy

This notice went into effect April 14, 2003. Austin Counseling Specialists LLC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that Austin Counseling Specialists LLC maintains. Austin Counseling Specialists LLC will provide you with a revised notice by mail, at the earliest opportunity following the revision.

Patient Consent: I have read and understand the information provided above regarding HIPAA and privacy practices. I have read this document carefully and understand the risks and benefits related to the use of privacy practices. I hereby give my informed consent to participate in the mental health treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

___________________________________ __________________
Client Signature Date

___________________________________ __________________
Therapist Signature Date