THE FLEXMAN CLINIC

NOTICE OF PRIVACY PRACTICES

How We May Use and Disclose Health Information:

Treatment: We may use and disclose health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose information to doctors, nurses, technicians and all other medical personnel who may be involved in your medical care.

Payment: We may use and disclose health information so that we or others may bill and receive payment from you, your insurance company and any third party for the treatment and services you received. For example, we may give your health insurance company health information so that they may pay for your treatment.

Health Care Operations: We may use and disclose health information for health care operations. These uses and disclosures are necessary to make sure that all of our patients receive quality care, and to operate and manage our office. For example, we may use and disclose information to make sure that the psychological care you receive is of the highest quality. We may also share information with others who have a relation with you (for example, your primary care physician) for their health care operation activities.

Appointment Reminders: We may use and disclose health information to contact you to remind you that you have an appointment with us. However, federal law prohibits us from leaving this information on an unauthorized voicemail system.

Individuals Involved in Your Care or Payment for your Care: When appropriate, we will share health information with a person who is involved in your medical care or payment for your care, such as a family member or close friend, with a signed release of information.

Special Situations:
As Required by Law: We will discuss health care information when required to do so by international, federal, state, or local law. For example, lawsuits and disputes, public health risks, inmates in custody, national security, coroners and medical examiner. It is further understood that my/our clinical records are confidential and will not be released to other persons or agencies without my/our written authorization except as follows: lawful serving of a subpoena; in the event of a valid medical, psychological or psychiatric emergency; in the event there is a reason to suspect child abuse or neglect has or is occurring (pursuant to Chapter 2151.421 of the Ohio Revised Code); on those occasions when clinical records are examined by authorized persons representing licensing or accrediting organizations for the sole purpose of conducting surveys or audits of this agency and its clinical services. Further, I understand that The Flexman Clinic mails statements on a monthly basis, and the statements are mailed in envelopes identifying The Flexman Clinic as the sender.

Business Associates: We may disclose health information to our business associates who perform functions on our behalf or provide services if the information is necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information, and are not allowed to disclose information, other than specified in our contract.

YOUR PATIENT PRIVACY RIGHTS

Right to inspect, copy, and amend: You have the right to inspect and copy health information that may be used to make decisions about your care or payment for care. You are not entitled to a photocopy of your file information. If you feel the health information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. You must make a written request to the office at our current address.

Right to Request Restrictions and Confidential Communication: You have the right to request a restriction or limitation on the health information we use or disclose for treatment, payment, business associates, health care operations, family and friends. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. We are not required to agree to your request. If we agree, we will comply with your request that we communicate with you about medical matters in a certain way or location. For example, by mail, at work or the appointment call notification system used in our office. To request confidential communication, you must make your request in writing to our office. Your request must specify how and where you wish to be contacted.

Consent to Treatment: The undersigned hereby grants permission to undergo psychological and/or psychiatric examination, evaluation, or testing for the purposes of determining diagnosis and/or treatment, or other professional mental health counseling services which are consistent with an individualized treatment plan to develop with my knowledge and consent.

Complaints: If you feel that your privacy has been violated you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Office Manager. All complaints must be in writing. You will not be penalized for filing a complaint.

Upon request you have a right to receive a paper copy of this notice. Notify the receptionist to obtain a copy for your records.

Patient Signature _____ Date _____