Christina Meighen, LLC
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Annapolis, MD 21401
410-424-5490

Notice of Privacy Practices AND Consent for Purposes of Treatment, Payment, and Healthcare Options

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective June 12, 2018, and applies to all protected health information contained in your health records maintained by me. I have the following duties regarding the maintenance, use and disclosure of your health records:
(1) I am required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of my legal duties and privacy practices with respect to that information.
(2) I am required to abide by the terms of this Notice currently in effect.
(3) I reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that I have and continue to maintain. All changes in this Notice will be prominently displayed and available on my website.

There are a number of situations in which I may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgment that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgment or Authorization. Under any circumstance, I will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure. I will attempt in good faith to obtain your signed Acknowledgment that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by this office once you have provided Consent.

Treatment: I will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom I need to consult with respect to your care.

Payment: I may need to use or disclose information in your health record to obtain payment from you for my services rendered to you. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in my business planning and development operations, including improvements in my methods of operation, and general administrative

functions. I may also use the information in my overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which I may use or disclose your health information without first obtaining your Acknowledgment or Authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, **I may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. I may also be required to report instances of suspected or documented abuse, neglect or domestic violence. I am required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity.** I must also provide health information when ordered by a court of law to do so. I may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Others Involved in Your Healthcare: Unless you object, I may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, I may disclose such information as necessary if I determine that it is in your best interest based on our professional judgment. I may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. For telemental health, it is imperative that you identify a support person who I will contact in the event of an emergency during our session. This person must be available and have access to you to assist in a crisis. Finally, I may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: I may use and disclose your protected health information if I attempt to obtain consent from you but are unable to do so because of substantial communication barriers and I determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. I may use or disclose your protected health information in an emergency treatment situation. If this happens, I will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If I am required by law or as a matter of necessity to treat you, and I have attempted to obtain your consent but have been unable to obtain your consent, I may still use or disclose your protected health information to treat you. Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. I likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of

injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain rights regarding your health record information, as follows:

(1) You may request that I restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. I am not required to agree to the restriction; however, if we agree, I will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy, and request amendments to your health records. Access to your health records will not include information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. I may charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to me at my address. I will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures I make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. I will not charge you for the first accounting in any twelve-month period; however, I will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish. You may file a written complaint to me or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to me (in the case of complaints to me) or to the person designated by the U.S. Department of Health and Human Services if I cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to: Christina Meighen, LCPC, Privacy Officer, 1997 Annapolis Exchange Parkway

Suite 300 Annapolis, MD 21401.

In this portion of the document, "I" and "my" refer to the patient, and "Therapist" refers to Christina Meighen, LCPC.

I consent to the use or disclosure of my protected health information by Therapist for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Therapist.

I understand that analysis, diagnosis or treatment of me by Therapist may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Therapist is not required to agree to the restrictions that I may request. However, if Therapist agrees to a restriction that I request, the restriction is binding on Therapist.

I have the right to revoke this consent, in writing, at any time, except to the extent that Therapist has taken action in reliance on this Consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Therapist and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Therapist. This Notice of Privacy Practices also describes the rights and duties of the Therapist with respect to my protected health information. Therapist reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice or privacy practices by calling the office of Therapist and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ (SEAL) _____

Signature of Patient Date

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Printed Name of Patient