



Acknowledgement of Receipt of Notice of Privacy Practices

Client Name: _____ DOB: _____

By my signature below, I _____ acknowledge that I received a copy of the Notice of Privacy Practices for Maggie E. Roney M.S., NCC, LPC

Client (Parent/Guardian if Minor)

Signature Date

Name of Client Printed

FOR OFFICE USE, ONLY

I attempted to obtain written acknowledgement of receipt of my Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented me from obtaining the acknowledgement
- Other: _____

Maggie E. Roney M.S., NCC, LPC

Signature Date

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.

I. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use of disclosure is made. And, I am legally required to follow the privacy practices described in the Notice. However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important change to my policies, I will promptly change this Notice and post a new copy of it in my office. You can also request a copy of this Notice from me, or you can view a copy of it in my office.

II. HOW I MAY USE AND DISCLOSE YOUR PHI

I may use and disclose your PHI for many different reasons. For some of these uses or disclosure, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

A. Permissible Uses and Disclosures Without Your Written Authorization

- 1. Treatment.** I may use your PHI in order to provide treatment to you. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you are being treated by a psychiatrist, I may disclose your PHI to your psychiatrist in order to coordinate your care.
- 2. Payment.** I may use or disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I may disclose your PHI to permit your health plan or insurance company to take certain actions before it approves or processing companies and others who may process my health care claims.
- 3. Health Care Operations.** I may use and disclose your PHI to operate my practice. For example, I may use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professional who provided such services to you. I may use and disclose your PHI in connection with quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.
- 4. Required or Permitted by Law.** I may use or disclose your PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, I may disclose your PHI to the extent necessary to avert a serious threat your health or safety or the health or safety of others. Other disclosure permitted or required by law include the following: disclosure for public health activities, health oversight activities including disclosure to state or federal agencies authorized to access PHPI, disclosure to judicial and law enforcement officials in response to a court order or other lawful process, disclosures for research when approved by an institutional review board, and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise authorized by law. I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

B. Permissible Uses and Disclosures Requiring Your Written Authorization

- 1. Psychotherapy Notes.** Notes recorded by me documenting the contents of a counseling session with you will be used only by your clinician and will not otherwise be used without your written authorization.
- 2. Marketing Communications.** I will not use your PHI for marketing communications without your written authorization.

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3. Other Uses and Disclosures. Uses or disclosures other than those described in Section II, A above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send your PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization in writing at any time to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.

III. YOUR INDIVIDUAL RIGHTS CONCERNING YOUR PHI

A. Right to Request Restrictions. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. If I accept your request, you may not limit the uses and disclosures that I am legally required or allowed to make.

B. The Right to Alternative Communications. You have the right to ask that I send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternative means (for example, e-mail instead of regular mail). I must agree to your request so long as I can easily provide PHI to you in the format requested.

C. The Rights to See and Get Copies of Your PHI. You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests must be made in writing. In certain situations, I may deny your request. I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. I may charge a fee for the costs of copying and sending you any records requested. (Note: State law may regulate such charges.) If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you.

D. The Right to Get a List of the Disclosures I Have Made. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete; (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial.

F. The Right to Obtain This Notice. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

IV. QUESTIONS AND COMPLAINTS

If you think that I may have violated your privacy rights you may file a complaint with me at Maggie E Roney M.S., NCC, LPC 101 S. Jackson Suite 200 Wylie, TX 75098. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independent Avenue S.W., Washington, DC 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

V. EFFECTIVE DATE AND CHANGE TO THIS NOTICE

A. This notice went into effect on January 1, 2006.

B. I may change the terms of this Notice at any time. If I change this Notice I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in the waiting room of my office. You may also obtain any revised notice by contacting me at Maggie E Roney M.S., NCC, LPC 101 S. Jackson Ave. Suite 200 Wylie, TX 75098.



Notice of Privacy Practices

Commitment to Privacy

The privacy of your health information is important to me. I will maintain the privacy of your health information and I will not disclose your information to others unless you tell me to do so, or unless the law authorizes or requires me to do so.

A new federal law commonly known as HIPAA requires that I take additional steps to keep you informed about how I may use information that is gathered in order to provide health care services to you. As part of this process, I am required to provide you with the attached NOTICE OF PRIVACY PRACTICES and to request that sign the attached written acknowledgement that you received a copy of the NOTICE. This notice describes how I may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information I maintain about you and a brief description of how you may exercise these rights.

If you have any questions, please contact me, Maggie E. Roney M.S., NCC, LPC (469) 693-1947