The Arbor Center PLC
10560 Main Street, Suite 410
Fairfax, VA 22030

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.

Pledge Regarding Medical Information

The privacy of your medical information is important to me. I understand that your medical information is personal and I am committed to protecting it. I create a record of care and services you receive at this practice. I need to maintain this record to provide you with quality care and to comply with certain legal requirements. This Notice will tell you about the ways I may use and share medical information about you. It also describes your rights and certain duties I have regarding the use and disclosure of medical information.

Legal Duty

With some exceptions listed below, I am required to keep your medical information private. I am also required to give you this Notice about my legal duties, privacy practices, and your rights regarding your medical information. I must follow the terms of the Notice of Privacy Practices which took effect on April 14, 2003 and remains in effect until replaced.

I reserve the right to change privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make changes in privacy practices and the new terms of this Notice effective for all medical information that I maintain, including information I created or received before the changes. You will be notified of any significant changes.

Use and Disclosure of Your Health Information

For Treatment: Medical information may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your mental health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose medical information to any other consultant only with your authorization.

For Payment: I may use and disclose medical information so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of information necessary for purposes of collection.

For Health Care Operations: I may use or disclose, as needed, your information in order to support business activities including, but not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard your privacy. For training or teaching purposes, that information will be disclosed only with your authorization.

Additional Uses and Disclosures of Your Medical Information That May Be Made Without Your Authorization or Opportunity to Object

I may use or disclose your medical information in the following situations without your consent or authorization.

Required by Law: Under the law, I must make disclosures of your medical information to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining compliance with the requirements of the Privacy Rule.

Legal Proceedings: I may disclose your medical information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful purpose.

Abuse or Neglect: I may disclose your health information to appropriate authorities if I reasonably believe that there is a possibility of abuse, neglect, domestic violence, or other crimes. I may disclose your medical information to the extent necessary to avoid a serious threat to your health or safety or the health or safety of others.

Imminent Threat to Health or Safety: I may disclose your mental health information to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission

I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Your Rights

Following is a brief statement of your rights with respect to your medical information and a brief description of how you may exercise these rights.

Access: You have the right to look at or get copies of your medical information, with limited exceptions. You must make your request to obtain medical information in writing. You will be charged a reasonable cost-based fee for expenses such as copies and staff time.

Accounting of Non-Routine Disclosures: You have the right to receive a list of instances in which I or my business associates disclosed your medical information for purposes other than treatment, payment or healthcare operations. It may exclude disclosures I may have made to you, or to family members and friends (with your authorization) involved in your care. You have the right to receive specific information regarding medical information disclosures that occurred after April 14, 2003.

Restriction: You have the right to request that we place additional restrictions on my use or disclosure of your medical information. I am not required to agree to these additional restrictions, but if I do, I will abide by our agreement (except in case of an emergency).

Alternative Communication: You have the right to request that I communicate with you about your medical condition by alternative means or to alternative locations. You must make your request in writing using the contact information at the end of this Notice. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you requested.

Amendment: You may request that I change your medical information. I may deny your request if I did not create the information you want changed or for certain other reasons. If I deny your request, I will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you want changed. If I accept your request to change the information, I will make reasonable efforts to tell others including people you name, of the change and to include the changes in any future sharing of information.

Questions and Complaints

If you have any questions about this Notice please contact:

The Arbor Center PLC
10560 Main St., Suite 410
Fairfax, VA 22030
Telephone: 703-352-8900

If you think I may have violated your privacy rights, you may submit a written complaint to me. You may also submit a written complaint to the U.S. Department of Health and Human Services. I will provide you with the address to file your complaint upon request.

Note

The Arbor Center is a group of independent practitioners who are solely responsible for their own clinical work.

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name _____

Date of Birth _____

I hereby acknowledge that I have received and have been given the opportunity to read a copy of The Arbor Center's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact:

The Arbor Center PLC
10560 Main St., Suite 410
Fairfax, VA 22030
Telephone: 703-352-8900

_____

Signature of Patient/Client **Date**

_____

Signature of Parent, Guardian or Personal Representative* **Date**

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*If you are signing as a Personal Representative of an individual, please describe your legal authority to act for this individual (power of attorney, health care surrogate, etc.).

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Signature of Therapist **Date**