Rachel Yost, LPCC-S, LICDC
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NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed, and how you can get access to this information.

OUR PLEDGE REGARDING HEALTH INFORMATION

I understand that health information about you and your health is personal and I am committed to maintaining the confidentiality of your health information. I create and maintain a record of the care and services that you receive. I need this record to treat you and to comply with certain legal requirements. This notice applies to all of the records of your care.

This notice advises you about the ways in which I may use and disclose health information about you. It also describes your rights to access and control your health information. 'Health Information' is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This notice also describes your rights and explains certain obligations I have regarding the use and disclosure of health information.

I am required by law to:

- Make sure that health information that identifies you is kept private.
- Provide you with this notice of my legal duties and privacy with respect to health information about you.
- Follow the terms described in this notice.

I may change the terms of this notice at any time. The new notice will be effective for all protected health information that I maintain at that time. Upon your request, I will provide you with any revised Notice of Privacy Practices by emailing me and requesting that a revised copy be sent to you in the mail, by asking for one at the time of your next visit, or by accessing my website.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that I may use and disclose health information. Not every use or disclosure in a category will necessarily be listed below. However, all of the ways which I am permitted to use and disclose information will fall within one of the categories.

Treatment: I may use and disclose your health information to provide, coordinate, or manage your mental health treatment and related services. For example, I may review information you provide during counseling sessions to develop and implement your treatment plan. With your authorization, or as otherwise permitted by law, I may communicate with other healthcare providers involved in your care to coordinate treatment. In certain circumstances, I may disclose relevant health information to individuals involved in your care, such as family members or other support persons, when appropriate and permitted by law. Because my practice is conducted through telehealth, I may use secure electronic communication and telehealth platforms to provide services and maintain clinical records.

Payment: I may use and disclose your health information to bill and collect payment for the counseling services I provide. For example, I may provide information to your health insurance company or other third-party payer regarding the services you received so that payment may be processed. This information may include your diagnosis, dates of service, type of treatment provided, and other information necessary to determine eligibility, coverage, or reimbursement. I may also disclose information to your health plan to obtain prior authorization for services or to verify whether a particular service is covered under your insurance benefits. If you choose to pay for services yourself and do not seek reimbursement from your insurance company, I will not disclose information to your insurer unless required by law or authorized by you.

Appointment Reminders: I may use and disclose health information in connection with my efforts to remind you that you have an appointment.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

Emergencies: If you experience a mental health or medical emergency, I may use or disclose your health information as necessary to obtain emergency assistance, ensure your safety, or coordinate your care. For example, I may contact emergency responders, a hospital, another healthcare provider, or an emergency contact if I believe there is an imminent risk of serious harm to you or another person. I will disclose only the information necessary to address the emergency and as permitted or required by law.

Uses and Disclosures Required or Permitted by Law: I may use or disclose your health information when required or permitted by federal, state, or local law. I will make such disclosures in accordance with applicable legal requirements and will limit the information disclosed to what is necessary.

Legal Proceedings and Law Enforcement: I may disclose health information in response to a valid court or administrative order, subpoena, discovery request, or other lawful process when required or permitted by law. I may also disclose limited information to law enforcement officials for purposes such as identifying or locating a suspect, victim, or witness; reporting suspected criminal conduct; responding to a crime that occurs in or is related to my practice; or as otherwise required by law.

Serious Threat to Health or Safety: I may use or disclose your health information when necessary to prevent or lessen a serious and imminent threat to your health or safety or the health and safety of another person or the public. Any disclosure will be limited to those reasonably able to help reduce or prevent the threat.

Special Situations: I may release health information in certain special circumstances as permitted or required by law, including to military command authorities if you are a member of the armed forces, to appropriate authorities for workers' compensation claims, and to health oversight agencies for legally authorized activities such as audits, licensing, and investigations.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Receive and Access a Copy of Your Records: You have the right to inspect and obtain a copy of your health and billing records, or request that a copy be sent to a third party

you designate. Your request must be made in writing. I may charge a reasonable fee for copying, mailing, or preparing records as permitted by law. In limited circumstances, I may deny access to certain information, such as information compiled in anticipation of legal proceedings. If access is denied, you may request a review of that decision by another licensed healthcare professional, as required by law.

Right to Request an Amendment: If you believe that information in your record is incorrect or incomplete, you may request an amendment. Your request must be submitted in writing and include a reason for the requested change. I may deny your request if the information is accurate, not created by me, or not available for inspection.

Right to Request Restrictions: You have the right to request limits on how I use or disclose your health information for treatment, payment, or healthcare operations. You may also request restrictions on disclosures to individuals involved in your care or payment. I am not required to agree to your request, but if I do, I will honor it unless the information is needed for emergency treatment.

Right to Request Confidential Communications: You have the right to request that I communicate with you in a specific way or at a specific location (for example, only by email or only at a certain phone number). I will accommodate reasonable requests.

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures of your health information, excluding disclosures made for treatment, payment, or healthcare operations, and other disclosures permitted or required by law. Your request must specify a time period of up to six years.

Right to a Paper Copy of This Notice: You have the right to receive a paper or electronic copy of this Notice at any time, even if you previously agreed to receive it electronically..

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

I certify that I have received this Notice of Privacy Practices for Rachel Yost, LPCC-S, LICDC. I understand that this Notice describes how my health information can be used and disclosed and how I can access this information.

Client Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Client Full Name: _____

PLEASE RETURN COMPLETED FORM VIA EMAIL TO counseling@rachel-yost.com