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***NOTICE OF PRIVACY PRACTICES***

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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.

Federal law, commonly known as HIPAA (Health Insurance Portability and Accountability Act) 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 you sign the attached written acknowledgement that you received a copy of the Notice. The Notice describes how I may use and disclose your protected health information 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 about this Notice please let me know.

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# NOTICE OF PRIVACY PRACTICES

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**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.**

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I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

For more information about my privacy practices, or for additional copies of this Notice, please contact me using the information listed in Section II G of this notice.

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## **I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

### **A. Permissible Uses and Disclosures without Your Written Authorization**

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. 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.

- 1. Treatment:** I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment.
- 2. Payment:** I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example, I may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.
- 3. Health Care Operations:** I may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.
- 4. Required or Permitted by Law:** I may use or disclose 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 PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures 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 as authorized by law.

### **B. Uses and Disclosures Requiring Your Written Authorization**

- 1. Psychotherapy Notes:** Notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.
- 2. Marketing Communications:** I will not use your health information for marketing communications without your written authorization.

**Other Uses and Disclosures:** Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time

## **II. YOUR INDIVIDUAL RIGHTS**

- A. Right to Inspect and Copy.** 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 for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. 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.
- B. Right to Alternative Communications.** You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.
- C. Right to Request Restrictions.** You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. I am not required to agree to any such restriction you may request.
- D. Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after January 1, 2009. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.
- E. Right to Request Amendment:** You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.
- F. Right to Obtain Notice.** You have the right to obtain a paper copy of this Notice by submitting a request to Jessica Miller at any time.
- G. Questions and Complaints.** If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact the **Privacy Officer**, *Jessica Miller MA, LMHCA at 1309 114<sup>th</sup> Ave SE Suite #104 Bellevue, WA 98004 or 425.999.5466*. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the Director or myself.

## **III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE**

- A. Effective Date.** This Notice is effective on April 14, 2003.
- B. Changes to this Notice.** 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 my office. You may also obtain any revised notice by contacting the Privacy Officer.
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## **Limits of Confidentiality**

The above information outlines federal law privacy practices. Washington State stipulates additional regulations on Confidentiality and the limits therein. Please find below the exceptions to confidentiality as described by the Washington State Department of Health.

**1) The client gives written permission to share confidential information.**

In the event you would like your file shared with a family member, an insurance company, another doctor or individual intimately involved in your immediate health, please let me know and I will provide a form for you to fill out which will then permit me to provide your information to the individual requested.

**2) Anything that suggests a crime or harmful act or any abuse to individuals unable to defend themselves such as minors or elders.**

Therapy holds the potential to stir up a mix of emotions some of which may be volatile in nature. If I believe my time with a client poses an immediate threat to either the client themselves or another individual, I am required to alert the appropriate authorities to ensure the safety of either individual. This includes, but is not limited to police, emergency personnel, hospital or the emergency contact you provided. If I believe another individual may be in danger, I will be alerting the appropriate authorities to ensure their safety as well as alerting the threatened individual.

**3) The client is threatening suicide or major self-harm and I am unable to obtain their agreement not to engage in such acts.**

Again, as stated above, therapy may stir up many emotions. If I feel a client is in immediate danger I will alert the appropriate authorities to maintain their safety.

**4) If the client is a minor, and there is indication that she/he was the victim or subject of a crime.**

In the event I am treating an individual under the age of 18 and information is revealed detailing or suggesting that client is the victim of sexual or physical abuse or a crime, I will alert the appropriate authorities and ensure the safety of the underage client.

**5) The client brings charges against the counselor.**

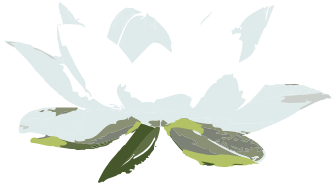
Time in therapy may not always be a smooth process. When a dispute occurs that we cannot resolve ourselves and a client chooses to involve litigation, I may choose to only disclose information as is pertinent to my own defense.

**6) In response to a subpoena**

Legal proceedings may come up during your time in therapy. In the event you choose to involve your mental health in a court case with you as the plaintiff, please be aware that the opposing side may attempt to gain and obtain the right to your psychotherapy records and/or testimony by your therapist.

**7) As required under chapter 26.44 RCW.**

This is the confidentiality code of the Department of Health (DOH) of Washington State. The code is subject to change as seen fit by the DOH. Any changes directly affecting my clientele will be made known to them at the earliest convenience.



Jessica L Miller MA, LMHCA

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
and LIMITS OF CONFIDENTIALITY**

By my signature below I, \_\_\_\_\_, acknowledge that I received a copy of the  
Notice of Privacy Practices and Limits of Confidentiality for Jessica L Miller, MA, LMHCA.

Client Signature \_\_\_\_\_

Date \_\_\_\_\_

*This form will be retained in your medical record.*

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**For Office Use Only**

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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