

**MINDBODY THERAPY & HEALING, INC.
19415 DEERFIELD AVENUE SUITE 307
LANSLOWNE, VIRGINIA 20176
703-729-0505**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

**Notice of Privacy Policy
Effective April 12, 2003**

We value you as a client and respect your right to privacy. We pledge our commitment to treating your information responsibly. We restrict access to your health information within MindBody Therapy & Healing, Inc. to those employees and contractors who need to know in order to provide appropriate treatment or services to you or to conduct MindBody Therapy & Healing, Inc. business on your behalf. This notice of health privacy policy is written in application to conducting a counseling practice.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information (protected health information or PHI) used or disclosed to us in any form whether electronically, on paper, or orally, be kept confidential. The federal law gives you, the patient, significant rights to understand and control how health information is used.

- 1. We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.**
- 2. We are required to give you this Statement about our privacy policy, our legal duties, and your rights concerning your health information.**
- 3. We are required to abide by the terms of the Notice currently in effect.**
- 4. We reserve the right to change the terms of the Notice at any time, provided such changes are permitted by applicable law, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available in printed form at our office.**

Your Personal Health Information

I collect personal health information from you through treatment, payment and related healthcare operations. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by counselors, healthcare practitioners, health care entities, as well as

health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement 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 Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

ONLY UNDER A SIGNED RELEASE

- 1. Treatment: It may be necessary to share your health information with another health care provider who we need to consult with in respect to your care. We do not disclose this information without your signed permission. A “Release Form” is provided for you to complete and sign and then with your permission the health care provider is contacted. Disclaimer: In the event of real threat or harm, physically or verbally, to yourself or another, the appropriate personal will be contacted.**
- 2. Your Authorization: You may give us a written release to use your health information for any purpose that you deem necessary. If you give us a release, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your release while it was in effect.**
- 3. Payment: You may ask us to disclose information about you with your health insurance company concerning claims/payment. You must sign a release form in order for us to do so.**
- 4. Individuals Involved in Your Care or Payment of Your Care: If family members are involved with your care, a signed release form gives permission for health information to be shared or contact calls to be made.**

WITHOUT A SIGNED RELEASE

- 1. Proper Authorities: We are required to report to appropriate agencies and law-enforcement official’s information that you or another person is in immediate threat of danger to health or safety as a result of violent activity.**

We may also be required to report instances of suspected or documented abuse, neglect or domestic violence.

2. **Required by Law:** Federal, state or local law, or when ordered by a court of law, may require us to use or disclose your health information.
3. **Public Health Risks:** We may disclose health information about you for public health activities such as to prevent or control disease, injury or disability, or to report reactions to medications or problems with products.
4. **Office Contact:** We may contact you from time to time to provide appointment reminders or to coordinate health-related information/services. We will speak with you directly unless we have written consent to do otherwise.
5. **E-mail Contact:** Due to the lack of “security controls and protection”, we do not use email correspondence. Contact counselors/staff by phone.
6. **Emergency/Notification Contact:** Your health record may be used to notify or assist family members, personal representatives or other persons responsible for your care in the event of an emergency or to enhance your well-being or your whereabouts. We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.
7. **Payment:** If you file claims with your health insurance company, from time to time claim adjusters contact the office to verify patient information or counselor verification. This information will be shared in order to process claims and payment. If you choose to pay by credit card, credit card information is processed daily.
8. **Operations:** Your health records may be used in our business planning and development operations including improvements in our methods of operation, and general administrative function. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

You have certain rights regarding your health record information.

1. **Access:** You have the right to request to look at or get copies of your health information. You must submit your request in writing to our office. A fee for copies, mailing, staff time or other associated fees will be charged. Counselors personal counseling notes of client sessions are not included.

2. **Inspect and Amend:** You have the right to inspect and request amendments to your health record. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by laws.
3. **Alternative Location:** You have the 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.
4. **Restrict:** You may request that we restrict the uses and disclosures or your health recorded information for treatment, payment and operations, of restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however if we agree, we will copy 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.
5. **Accounting:** You have a limited right to receive an accounting of all disclosures we 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. We will not charge you for the first accounting in any 12-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same 12-month period.
6. **Electronically:** 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.

If you would like to submit a complaint directly to the US Department of Health & Human Services, please send it to the following address:
USS Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W. Washington, D.C. 20201 877.696.6775

NOTICE OF PRIVACY PRACTICES AVAILABILITY

The terms described in this notices will be posted where registration occurs. All individuals receiving care will be given a hard copy.

Client's Signature

Client's Printed Name

Date