Bardenstein Family Center

Privacy Policy Notice

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures of PHI (Personal Health Information)

We may use your protected personal health care information for treatment, payment and health care operations without your consent under the Health Insurance Portability and Accountability Act (HIPAA). PHI refers to any information in your health care record that can identify you. Ohio law requires that you provide informed consent regarding the purposes of the services, limits to the services due to legal requirements, relevant costs, reasonable alternatives, your right to reuse or withdraw consent, and the time frame covered by consent. We also ask your consent to submit information for payment purposes, including submission of claims to third party payors, for collection purposes, or for other legal purposes.

Treatment: We can use your PHI when we provide, coordinate or manage your health care, such as consulting with your family physician or another mental health professional.

Payment: We use your PHI to obtain reimbursement for health care, such as communicating with your insurance company.

Health Care Operations: Any quality assessment, case management or other activity involving the performance of the practice may use your PHI.

Uses and Disclosures Requiring Authorization

"Use" applies to activities within our practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside of our practice, such as releasing, transferring or providing information about you to other parties.

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate and specified authorization is obtained. We also need to obtain your authorization before releasing your psychotherapy notes, except under certain limited circumstances. Psychotherapy notes are notes we have made about the conversation you have with your mental health professional during a private, group, joint or family counseling session, which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than other PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization: (1) to the extent that we have relied on the authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

Consent and Disclosure when the patient is a minor child (less than 18 years of age)

Parents are, in general, entitled to their child's records, including any documentation of an adult's communication to the therapist regarding the child or participation in the child's session. If a parent wants his/her communication to the therapist to be confidential and not shared with the other parent, such confidentiality requires each parent to give consent to be identified as a patient, independently of the child patient. Alternatively, both parents can provide written authorization and consent, before the treatment of the child begins, that their parent/child meetings or individual parent sessions will not be shared with the other parent or third party without their consent.

Uses and Disclosures with Neither Consent or Authorization Required

We may use or disclose PHI without your consent or authorization in the following circumstances.

Child Abuse:

If, in our professional capacity as mental health professionals, with some limited exceptions, we learn or suspect that a child under 18 years of age, or a developmentally delayed or disabled or physically impaired child under 21 years of age has suffered or faces threats of suffering any physical or mental wound, injury, disability or condition that indicates abuse or suspicion, we are required to make a report to the appropriate Ohio Children Services Agency or a municipal or county peace officer in the county in which the child resides or in which the abuse or neglect has occurred.

Elder and Domestic Abuse:

If we have reasonable cause to believe that an adult who is sixty years of age or older, or who is handicapped by the infirmities of aging or has a physical or mental impairment which prevents the person from providing for the person's own care and protection, and who resides in an independent living arrangement, is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, then we, as mental health professionals, are required by law to immediately report such belief to the County Department of Job and Family Services. For domestic abuse, the law requires mental health professionals to note the knowledge or belief of the abuse and the basis for it in the patient's or client's record.

Abuse Involving a Developmentally Delayed/Disabled Person:

If we have reasonable cause to believe that a developmentally delayed/disabled adult has suffered a wound, injury, disability, or condition as to reasonably indicate abuse or neglect of that adult, we must immediately make a report to a law enforcement agency or to the county board of developmental disability; or if the person is in a state facility, the law enforcement agency or to the department of developmental disability.

Judicial or Administrative Proceedings:

If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release this information without written authorization from you or your personal, legally appointed representative or court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety:

If we believe that you pose a clear and substantial risk of imminent serious harm to yourself or another person, your relevant confidential information may be disclosed to public authorities, the potential victim, other professionals and/or your family in order to protect against such harm. If you or a knowledgeable person communicates to your mental health therapist an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and your therapist believes you have the intent and ability to carry out the threat, then the therapist may take one or more of the following actions in a timely manner: (1) take steps to hospitalize you on an emergency basis; (2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional; (3) communicate to a law enforcement agency and, if feasible, to the potential victim (s), or victim's parent or guardian; (a) the nature of the threat; (b) the therapist's identity; and (c) the identity of the potential victim(s).

Worker's Compensation:

If you file a worker's compensation claim, your mental health professional may be required to give your mental health information to relevant parties and official, even without your authorization.

Patients' Rights and Mental Health Therapist's Duties

Patients have the right to:

Request Restrictions: on certain uses and disclosures of protected health information about themselves. However, we are not required to agree to a restriction that you request. This restriction on uses and disclosures may not include a limitation affecting our right to make a use or disclosure that is required by law or, when in good faith, to use or disclose to avert a serious threat to health or safety of a person or the public and such use for disclosure is made to a person or persons reasonably able to present or lessen the threat (including the target of the threat).

Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right, for example, to request that we send bills to another address so that family members do not see them; or, you may request that we not call you at home. Upon your request, we will contact you at another phone number.

Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record and the information has been collected for treatment purposes. There are some limited exceptions where you will not be permitted to inspect and copy records involving your PHI, but, in those circumstances, we will provide you with reasons for any denial of access and notify you of any appeal rights that you may have.

Right to Amend: If you have the right to inspect and copy your records, you have the right to request an amendment of PHI as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

Right to an Accounting of Disclosures: In general, you have the right to receive an accounting of disclosures of PHI involving disclosure for other purposes than treatment, payment, or health care operations or pursuant to an authorization (as described in this notice). On your request, we will discuss with you the details of the accounting process.

Right to a Paper Copy: You have the right to obtain a paper copy of the notice from us, upon request, even if you have agreed to receive the notice electronically.

Our Duties:

We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

We reserve the right to change the privacy policies and practices described in this notice. Unless we provide you with a notice of such changes, we are required to, however, to abide by the terms currently in effect.

If we revise our Notice of Privacy Practices form, we will distribute copies to you of your new Notice as required by HIPAA.

Complaints:

If you are concerned that we have violated your privacy rights, or you disagree with a decision we make about your access to records, you may contact us at our office: 216 229-4200. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We can provide you with the appropriate address upon request.

Effective Date: This notice went into effect on April 14, 2003 and was revised/reviewed on April 5, 2022.

Bardenstein Family Center

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE FORM

By signing this document, I acknowledge that I have received a copy of the Notice of Privacy Practices. I also acknowledge that I have had a chance to ask questions about it.

_____	_____	_____
Name of client (print)	Signature	Date

GUARDIAN/PERSONAL REPRESENTATIVE

_____	_____	_____
Name (Print)	Signature	Date

Provide description of legal authority (For example, Legal Guardian, Durable Power of Attorney for Health Care, other legal authority)

Therapist's use only below:

Date that acknowledgment was reviewed and signed: _____