



The Center for Sexual Health and Family Counseling of Orlando, LLC
Individual, Couples and Family Therapy

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HIPAA Notice of Privacy Practices

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

The privacy of your information is important to us. The Center for Sexual Health and Family Counseling of Orlando, LLC DBA Empowerment Counseling Center, referred to hence forth as: "CSHFCO", understands that your information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share information about you. We also describe your rights and certain duties we have regarding the use and disclosure of your health information. Information is only released in accordance with state and federal laws and the ethics of the counseling profession. This notice describes our policies related to the use and disclosure of your health care information, specifically: *protected health information (PHI)*.

The law requires us to:

1. Keep your PHI private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your information.
3. Follow the terms of the notice that is now in effect.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the law permits the changes.
2. Make the changes in our privacy practices and the terms of our notice effective for all information that we keep, including information previously created or received before the changes.
3. If we revise the policies and procedures, we will make our best effort to contact you with this information either in person, by telephone, or by mail, or any other arrangements that are made.

Notice of Change to Privacy Practices

Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Uses and Disclosure of Your Medical/Mental Health Information

The following section describes different ways that we use and disclose information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose information. We will not use or disclose your information for any purposes not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time in writing to us.

In the Event of a Patient's Death

In the event of a patient's death, the spouse or parents of a deceased patient have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

Health care professionals are required to release records of patient(s) when a court order has been placed.

Duty to Warn and Protect

When a patient discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the patient discloses or implies a plan for suicide or self-harm, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the patient(s).

Minors/Guardianship

Parents or legal guardians of non-emancipated minor patient(s) have the right to access the patient(s)' records.

Other Provisions

1. When payment for services are the responsibility of the patient(s), or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the patient(s)' credit report may state the amount owed, the time-frame, and the name of the clinic or collection source. Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the patient. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy and summaries.
2. Information about patient(s) may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the patient, or any identifying information, is not disclosed. Clinical information about the patient(s) is discussed. Some progress notes and reports are dictated/typed within CSHFCO or by outside sources specializing in (and held accountable for) such procedures.
3. In the event in which CSHFCO or mental health professional must telephone the patient(s) for purposes such as: appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of CSHFCO or the nature of the call, but rather the mental health professional's first name only. If this information is not indicated on the **Patient Information Form**, we will adhere to the following procedure when making phone calls: First we will ask to speak to the patient (or guardian) without identifying the name of CSHFCO. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify CSHFCO (to protect confidentiality). If we reach an answering machine or voicemail we will follow the same guidelines.

For Treatment

We may use medical information about you to provide you with services. We may disclose information about you to students for the purpose of education or training, or to professional colleagues for the purpose of case review and treatment planning. However, in these cases, no identifying information is provided.

For Payment

We may use and disclose your information for payment purposes.

For Health Care Operations

We may use and disclose your information for our health care operations. This might include measuring and improving quality, conducting training, and getting the accreditations, certifications, licenses, and credentials we need to serve you.

Notification

In case of emergency in scheduling or psychological conditions, we will notify a family member, your personal representative, or another person designated by you on the **Patient Information Form** if you are unavailable or unreachable. We will share only the information that is directly necessary for your care, according to our professional judgment.

Court Orders and Judicial and Administrative Proceedings

We may disclose medical/mental health information in response to a judicial order, under certain circumstances. Under limited circumstances, we may share your information with law enforcement officials. We may share limited information with a law enforcement official concerning the information of a crime victim or missing person.

Public Health Activities

As required by law, we may disclose your information to legal authorities charged with preventing injury or harm, including child or elderly abuse or neglect.

Victims of Abuse, Neglect, or Domestic Violence

We may disclose information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence. We may share your information if it is necessary to prevent a serious threat to your health or safety, or the health or safety of others.

Workers Compensation

We may disclose health information when authorized and necessary to comply with laws relating to workers' compensation or other similar programs.

Health Oversight Activities

We may disclose information to an agency providing health oversight for activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Your Rights:

1. Look at and/or obtain copies of a treatment summary regarding your treatment/medical files. State law allows that specific treatment notes need not be supplied. However, you do have the right to review your treatment records in the presence of the therapist or a representative appointed by the therapist. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. You may request that we provide copies of the treatment summary in a format other than photocopies. We will use the format you requested unless it is not practical for us to do so and you must make your request in writing. You may get the form to request access by using the contact person listed at the end of this notice. If you request copies, we will charge you \$1.00 per page and postage if you want the copies mailed to you. If you wish to have copies faxed to you, or to another person or facility authorized in writing by you, we will charge you \$1.00 per page and a transmission fee of \$3.00. These fees must be paid prior to the release of information.
2. Right to Release Your Medical Records- At CSHFCO we require a written authorization to release records to others. You have a right to revoke this release at any time by submitting a letter to this office.
3. Receive a list of all times we shared your information for purposes other than treatment payment, health care operations and other specified exceptions. Exceptions include: disclosure for treatment, payment or other healthcare operations, disclosures pursuant to a signed release, disclosures made to client, and disclosures for national security or law enforcement.
4. Request that we place additional restrictions on our use or disclosure of your information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
5. Request that we communicate with you about your information by different means or to different locations. For example, you might not want a family member to know that you are in treatment; therefore, you might request that all correspondences are sent to another address. Your request that we communicate your information to you by different means or different locations must be made in writing to the contact person listed at the end of this notice.
6. Request that we add information or amend your medical records. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we 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 we accept your request to change the information, we will make reasonable efforts to tell others, including people you name of the change and to include the changes in any future sharing of that information.
7. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request to the Privacy Officer listed at the end of this notice.
8. Right to request where we can contact you. This information is indicated on the **Patient Information Form**.

Questions and Complaints

If you have any questions about this notice or if you believe your privacy rights have been violated you should call the matter to our attention by filling out a complaint form as provided by CSHFCO upon request outlining your concern to Arnaldo Luis Olivera II, Ph.D., LMFT, CCS - Privacy officer to the same address:

Contact Person

Arnaldo Luis Olivera II, Ph.D., LMFT, CCS - Privacy Officer
1260 Palmetto Avenue Suite F
Winter Park, FL 32789
Phone: (407) 775-2949
Fax: (844) 410-8878

If you are not satisfied after exercising the above choice, you may also submit a written complaint to the Florida Department of Health. I will not retaliate against you in any way for filing a complaint with me or with the Florida Department of Health. The address for the Florida Department of Health is: Florida Department of Health Division of Medical Quality Assurance 4052 Bald Cypress Way Tallahassee, FL 32399-3250.

Effective Date: This notice is effective on or after March 27, 2017

OMNIBUS HIPPA EFFECTIVE MARCH 27, 2017

Receipt and Acknowledgement of HIPAA - Notice of Privacy Practices

Patient Name _____

Date of Birth _____ Social Security Number _____

I _____ hereby acknowledge that I have been given an opportunity to read, review, and obtain a copy of The Center for Sexual Health and Family Counseling of Orlando, LLC, DBA Empowerment Counseling Center, (CSHFCCO) HIPAA Notice of Privacy Practices for protected health information. I also understand that if I have any questions regarding the notice of my privacy rights or if I feel that I have complaints, I may contact: Arnaldo Luis Olivera II, Ph.D., LMFT, CCS - Privacy Officer at (407) 775-2949.

You may also contact the U.S. Department and Health and Human Services with any concerns regarding our privacy and security policies. Please contact our office for information on how to contact U.S. Department of Health and Human Services.

The following measures have been taken to notify patient of Notice of Privacy Practices by The Center for Sexual Health and Family Counseling of Orlando, LLC:

- Showing the patient, the Notice of Privacy Practices posted in our office.
- Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- Asking the patient to sign this Acknowledgement form.

Name of Patient (Print Name)

Date

Signature of Patient

Date

Signature of Parent or Legal Guardian or
Authorized Representative**

Date

** If you are signing as a Personal Representative of an individual, please describe your legal authority to act for this individual (e.g., Power of Attorney, Healthcare Surrogate, etc.)

ONLY FOR OFFICE PERSONNEL USE

Documentation of Good Faith Effort to Obtain Written Acknowledgement I made a good faith effort to obtain the patient's written acknowledgement of our Notice of Privacy Practices for protected health information.

I was unable to obtain the patient's written Acknowledgement because (check all that apply):

- Patient Refuses to Acknowledge Receipt/ sign this form
- Other (Explain in detail): _____

Copy of NPP:

- Patient did **not** wish to obtain a copy
- Patient was given a copy of NPP

Personnel (staff) Representative: _____

DATE: _____

Notes: This written Acknowledgement must be completed no later than the first date health care services or treatments are provided to the patient. This Acknowledgement must be retained in the patient's permanent record.

Witness: _____