Jessica Sauer, LCSW
Brand New Day Counseling, LLC
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HIPPA ACKNOWLEDGEMENT & NOTICE OF PRIVACY PRACTICES

This notice involves your privacy rights and describes how information about you is protected and may be disclosed, as well as how you can obtain access to this information. Please review it carefully.

Client Name:_____ Date:_____

I. CONFIDENTIALITY

As a mental health professional, I keep records about our work together. As a rule, I will not disclose information about you, or the fact that you are my client, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, a diagnosis if applicable, functional status, symptoms, prognosis and progress, and any assessment tools administered or obtained. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing a general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me. Unless I feel it would be significantly harmful to you, you are able to access your record at any time.

II. LIMITS OF CONFIDENTIALITY

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization: There are some important exceptions to the rule of confidentiality - some exceptions created voluntarily by my own choice, and some required by law. If you wish to receive mental health services from me, I require that you sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

Emergency: If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by Florida law to report the matter immediately to the Abuse Hotline at 1-800-96-ABUSE.

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Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Florida law to immediately make a report and provide relevant information to the Abuse Hotline at 1-800-96-ABUSE.

Court Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you. If there is a criminal or civil case being pursued or considered I ask that you advise me as this makes records more subject to being requested and may have an effect on your response to therapeutic services provided.

Serious Threat to Health or Safety to Self: Under Florida law, if I am engaged in my professional duties and you indicate an intent and verbalize means to bring harm to yourself I am required to take steps to ensure your safety. If you indicate an intent and verbalize means to complete or attempt a suicidal gesture I am required to take steps to ensure your safety. For both of these instances voluntary or involuntary hospitalization will be utilized and Baker Act procedures initiated to minimize the likelihood that you will be able to bring harm or fatal injury upon yourself.

Serious Threat to Health or Safety to Others: Under Florida law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to inform the third, or threatened party. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety.

Workers Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

Insurance Requirements: Your insurance company has the right to access your progress notes at any time as a term of payment for services, and to verify that the services provided were medically necessary.

Records of Minors: Florida law limits the confidentiality of the records of minors. For example, parents may not be denied access to their child's records. Other circumstances may also apply, and we will

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discuss these in detail if I provide services to minors. Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

Electronic Communication: I cannot guarantee your confidentiality with ***any*** electronic communication due to the uncontrollable circumstances that occur with such devices and applications including, but not limited to: Email, Skype (or any other type of video/conference call service), chat, texts, telephone conversation or facsimile. Communication via any of these means should be kept to a minimum and is performed at the risk of the client.

III. PATIENT'S RIGHTS AND PROVIDER'S DUTIES

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request but will do my best to disclose the minimum necessary information. To request restrictions, you must make your request in writing, and tell me: 1) What information you want to limit; 2) whether you want to limit my use, disclosure or both; 3) to whom you want the limits to apply.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

I cannot schedule, confirm, adjust or cancel an appointment for anyone other than the client being seen unless a signed release of information is on file, or if the client is a minor. If you and your spouse/partner are being seen together for the indicated session, it is acceptable for one party to schedule, confirm, adjust or cancel an appointment. However, I will not notify the other spouse/partner of the change. In the event of a family or medical emergency, a note will be made on the account without disclosing information to a third party or family member unless a release is on file.

Right to an Accounting of Disclosures: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice).

Right to Inspect and Copy: In most cases, you have the right to inspect and copy your medical and billing records, however, psychotherapy notes are excluded from this practice by Florida law. To do this, you

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must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding. If you would like a copy or summary of your records, I require 15 business days of written notice via "Authorization for Use or Disclosure of Personal Health Information (PHI)" form and will charge a fee of $.25/paper page plus postal fees if you would like your copies mailed. Summaries are billed at your regular hourly rate. Oftentimes, clients request copies of records with the intent of securing a treatment summary for an outside entity. Requesting a summary is often in your best interest, as it protects your confidentiality. This is often preferable to giving someone access to your entire treatment record.

Right to Amend: If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

Right to a Copy of This Notice: You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time.

Changes to This Notice: I reserve the right to change my policies and/or to change this notice, and to make the change notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the office. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you may submit your complaint in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services or visit their website at www.hhs.gov.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

Signature _____ Date _____

Effective 08/11/2021