KORMAN AND ASSOCIATES, P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW 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 HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on April 1, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please ask your therapist or our privacy officer.

USES AND DISCLOSURES OF HEALTH INFORMATION

The information you share with your therapist is confidential and cannot be shared with anyone without your written permission. The exceptions to this are outlined in the Confidentiality handout you received at the time of your first visit. Additional copies are available from your therapist or any staff member.

Certain health information about you is used and disclosed for the purposes of payment and health care operations.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, in order to file an insurance claim for you, we must disclose your diagnosis and dates of treatment to your insurance company. Additionally, if your insurance plan requires precertification and/or authorizations for ongoing care, we may disclose your health information to the plan care management or utilization review department in order to secure the authorization on your behalf.

Healthcare operations: We may use and disclose your health information in connection with our healthcare operations. An example of this would be peer supervision or quality assessment and improvement activities, although if a medical record is used for one of these reasons, it would be de-identified.

Your Authorization: You may give us written authorization to disclose your health information to anyone for any purpose. For example, you may wish us to consult with your other healthcare

providers or confer with family members. If you give us an authorization to disclose your information, you may revoke it in writing at any time. Your revocation will be effective immediately upon our receipt but is not applicable to the information that may have already been disclosed while the authorization was in effect.

Marketing Activities: We will not disclose your health information for marketing communications without your permission.

Appointment Reminders: We generally call/ text or email the day before a scheduled appointment to confirm or remind you of the appointment. If you do not wish to receive a reminder (via phone call, voice mail message, text or email), please notify your therapist.

CLIENT RIGHTS

In general, you have a right to access your health information. If you wish to see your medical record, you have to right to do so unless your therapist believes it is not in your best interest. You may review your medical record in the presence of your therapist.

You have the right to request that we place additional restrictions on our use of your health information. While we are not required to agree to these additional restrictions, if we do, we will abide by our agreement.

You have the right to receive a list of instances in which we disclosed your health information for the last 6 years, on or after April 14, 2003. If you request this information more that once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

You have the right to complain to your therapist and/or the secretary of Health and Human Services if you believe a violation of your privacy rights has occurred. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

If you have questions or concerns about our Privacy Practices, please notify your therapist or you may contact our privacy officer:
Name: Felicia Korman
Telephone: 817/563-4949Fax: 817/563-4941
Address: 6001 W Interstate 20, Ste. 216, Arlington, Texas 76017

To Contact the U.S. Department of Health and Human Services call 1-866-627-7748

I have reviewed a copy of the Notice of Privacy Practices and understand that I may discuss any concerns or questions that I may have with my therapist or the privacy officer. Furthermore, I understand that I may also contact the U.S. Dept. of Health and Human services if I believe there has been a violation of my privacy rights.

Signed:_____ Date:_____

Client Name:_____
Relationship to client: (Please circle) self parent/guardian

COURTESY APPOINTMENT REMINDERS

We can send appointment reminders by email and/or text. The reminder will include the date, time of appointment and provider's name. The message will NOT be encrypted. Information sent by regular email or text can be lost, delayed, intercepted, delivered to the wrong address or arrive incomplete of corrupted. If you understand these risks and would like to receive an appointment reminder by email, text or both please initial below and provide your email address and/or cell number below. By providing this information you accept responsibility for the risks and will not hold us responsible for any event that occurs after we send the message.

Please initial below if you consent to receiving appointment reminders by each method.

___ email to _____.
(please list preferred email address)

___ text message via cell phone _____.

___ land line phone, with voice mail message or message left with whomever answers the phone