



480.331.5002

www.excelsocialservices.com

Notice of Privacy Practices

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

A. Introduction

Privacy is an important part of our practice. Due to ethical guidelines and the many federal and state laws surrounding privacy, it is complicated, which makes parts of this notice very detailed. If you have any questions on this notice, I (the privacy officer) will be happy to answer them. This notice will detail how we use and disclose medical/health information as well as your rights to your medical/health information.

*Please note that we/us in this notice refers to Excel Social Services Inc., and its owner-Lady Esther Agyepong, MSW, LCSW, MBA

B. Medical Information

Anytime you visit a healthcare provider, either for physical or mental health care, information is collected about you and your health. The information collected can be related to your past, present, or future health, related to tests/treatment you received from us or others, or related to payment for healthcare services. The information that is collected from you is, by law, called **PHI (Protected Healthcare Information)** and is part of your medical or healthcare record.

At this office, PHI is likely to include information about the following;

- Your personal history
- Reasons for treatment
- Diagnoses (a term indicating a problem/symptom)
- A treatment plan, which is a list of treatments/services that we believe will best assist you.
- Progress Notes, which are a record of our interaction each time we meet
- Records from other healthcare providers you have been to see

- Psychological test scores/school records/additional evaluations or reports
- Medical information including medications you have been prescribed and/or are taking
- Legal matters
- Billing and Insurance information

*The above list is to provide you an understanding of what might be in your record; however, there might be other information included in your record.

We use your PHI for multiple purposes, which may include the following:

- For planning and implementing care and treatment
- To assess the effectiveness of treatment
- For talking with other healthcare professionals such as your doctor
- For documentation that you received the services from us we indicated for billing purposes of you or your insurance company
- For teaching or training other healthcare professionals
- For medical/psychological research
- For public health officials who are striving toward improving health care in this part of the country
- To be able to measure the results of our work so as to improve the way we provide treatment

It is helpful to understand what is part of your record and what it is used for so as you can make the best decision about who, when, and why others should have this information.

Your health record is the physical property of the practitioner or agency that collected it; however, the information belongs to you. You can read the information in your file, and if you would like a copy of the information, we can make one for you but may charge you for copying and shipping costs. In some situations, such as with psychotherapy notes, you cannot see all of what is in your record. You can ask to amend any incorrect information you encounter in your record or add any information you feel is missing; however, in some instances, we do not have to agree to do that. You can consult with the privacy officer for further information or clarification.

C. Privacy and the laws

We are required by law to inform you of privacy because of privacy regulations due to the Health Insurance Portability Accountability Act of 1996 (HIPAA). The HIPAA law requires us to keep your PHI private and requires us to notify you of our legal duties and privacy practices, called the Notice of Privacy Practices (NPP). We will follow the rules of this notice as it remains in effect; however, any changes to the NPP will apply to all the PHI that we keep. If we change the NPP, we will provide you an updated copy. You can also ask the privacy officer at any time for a copy of this notice.

D. How your protected health information (PHI) can be used or shared

Use: When your information is read by others or me in this office and used to make decisions about your care

Disclosure: When your information is shared with or sent to others outside the office We share the **minimum necessary information** in disclosure to others, except to special circumstances. Due to your legal rights, we will further explain your PHI, how it is used and how to have a say in how information is disclosed.

Typically, we use and disclose your information for routine purpose, explained further below. For other uses/disclosures of information, we must inform you of them and obtain your written authorization, unless the law requires us to disclose information without your authorization as the law states in certain circumstances, we do not need your authorization to disclose information.

1. Uses and disclosures of PHI in healthcare with your **CONSENT**

At the end of reading this notice, you will be asked to sign a consent form, allowing us to use or share your PHI. In most cases, we use your PHI to provide **treatment** to you, obtain **payment** for services, or for use in other business functions called health care **operations**. In short, these routine purposes are called **TPO**, and the signed consent form allows us to disclose your PHI for TPO.

1a. (TPO) For treatment, payment, or other health care operations.

In order to begin treatment, we must have your consent to allow us to collect and share information as we need information about you and your condition in order to provide appropriate care and services. We cannot treat you without a signed consent form. The information we collect about you may go into your healthcare records at this office and is generally use for treatment, obtaining payment, and healthcare operations.

Treatment: Your medical information is used to provide you with therapeutic services and treatment, including, but not limited to, individual/couples/family therapy, treatment planning, outcome measures, supervised visitation. We may share/discard your information with others who provide you treatment such as a psychiatrist or physician. This will allow us to work with other members of your treatment team and you to identify what will work best for you and make a treatment plan. We might refer you to other providers for services we are unable to provide and will need to be able to share with them PHI. We can also share PHI with professionals whom you work with in the future.

For Payment: We may use your information for billing you, your insurance, or others so that we can be paid for the services we provide. We may need to be in contact with your insurance to find out what your insurance covers, inform them of your diagnoses, report on the treatments/services you have received, and discuss the changes we anticipate in your

conditions. Additionally, we will need to discuss with insurance other matters such as when we met and your progress.

For Health Care Operations: We may use your PHI for health care options such as for improvement in services and care or as information for government agencies to utilize for studies. If your information is used, your name and personal information will be removed from the information submitted.

1b. Other uses in healthcare Appointment Reminders:

Your PHI might be used to reschedule or give appointment reminders. If you prefer a particular method of contact, such as contact only at home, please let us know, and we can work to accommodate your request.

Treatment Alternatives: We may use/disclose your PHI to inform you of or recommend particular treatment or alternative that may be of benefit to you.

Other benefits and services: We may use/disclose your PHI to inform you of additional health-related benefits or services that might be of personal interest.

Research: We may use/disclose your PHI for research purposes geared toward improving treatment. For example, research around comparison of two treatments for the same disorder around cost and treatment effectiveness. Your name and identifying information would be removed from all information given to researchers. If your personal information is needed for the research, we would discuss the research with you and only disclose your information with your written authorization.

Business Associates: We require the assistance of other businesses in our job. By law, they are called “business associates”. Examples include a billing service or copy service. In order to effectively do their jobs, these business associates need to have some access to your PHI. They have agreed to protect your privacy as part of their work with us.

1. Uses and disclosures that require your **AUTHORIZATION**

If we want to use your information for any other purposes than TPO or those discussed above, we require your permission through an Authorization form. If you authorize release of your information, you or we can revoke that authorization at any time, at which point we would no longer use or disclose your information; however, we cannot take back any information that has already been released. We can also not protect information that has been released to others.

2. Uses and disclosure of PHI from mental health records that **DO NOT REQUIRE** a consent or authorization

Listed below are examples of situations in which by law, we are allowed to release your PHI without your consent or authorization:

When required by law

- Suspicion of child abuse
- By subpoena, discovery request, or other lawful request due to your involvement in a lawsuit or legal proceeding. We might attempt to contact you about the request, consult with your lawyer if able, or attempt to obtain a court order to protect the privileged information requested.
- To government agencies that are checking our compliance with privacy laws

For law enforcement purposes

- We may release PHI upon the request of a law enforcement office or official due to a criminal investigation.

For public health activities

- We may disclose your PHI to agencies that investigate diseases or injuries.

Relating to decedents

- We may disclose PHI to coroners, medical examiners or funeral directors as well as to organizations related to organ and tissue donation and transplant.

For specific government functions

- We may disclose PHI of military personnel and veterans to government programs for benefits related to eligibility and enrollment. Additionally, we may disclose your PHI to Workers Compensation and Disability programs, to correctional facilities if you are an inmate, and for national security reasons.

To prevent a serious threat to health and/or safety

- We may disclose your PHI if we believe there is a serious threat to your health or safety or that of another person or the public. We will only disclose information to people who can potentially prevent the danger.

3. Uses and disclosures where you have an opportunity to object

We can share some information about you with family or close others; however, we will only share information with those involved in your care and anyone else you identify as necessary. You will let us know who you want us to share information with and how much to share about the nature of your treatment. We will work to honor your requests as long as it is not against the law.

In the event of an emergency, so we cannot ask if you disagree, we can share information if we believe that it would be your wish and if it would be of assistance for you. In the event of an

emergency in which information is released, we will inform you as soon as we can and will cease disclosure as long as it is not against the law.

4. An accounting of disclosures

We may, when we disclose your PHI, keep some records regarding the disclosure such as to whom the information was sent, when we sent it, and the information that was sent. For many of these disclosures, you can get an accounting of these disclosures.

E. Your rights regarding your health information

1. You have the right to ask us to communicate with you about health related issues in a particular way or place that is more private for you. We will try to accommodate your requests.

2. You have the right to ask us to limit our disclosures to people involved in your care whether for payment, family, or other individuals. We are not required to agree to your request; however, if we do agree, we will maintain our agreement except when against the law, in an emergency, or when the information is necessary to treat you.

3. You have the right to examine your information, such as medical or billing records (excluding psychotherapy notes). You may be able to receive a copy of these records upon request to our agency and by paying a fee.

4. You have the right to ask to amend or add information to your record; however, you must submit a written request to our Privacy Officer for review.

5. You have the right to a copy of this notice. If we amend this notice, we will give you a copy. You have the right to file a privacy complaint if you feel your privacy rights have been violated and can file a complaint with our Privacy Officer or the Department of Health and Human Services.

Additionally, you may have other rights granted to you by state law, which may be the same or different than the ones described above. We will be happy to discuss them now or as situations arise.

F. If you have questions or problems

If you have concerns about how your information has been handled or questions about this notice, please feel free to contact our **Privacy Officer, Lady Esther Agyepong at 480-331-5002 or excelssinc@gmail.com**. You have a right to file a complaint with us and the Department of Health and Human Services, and no retaliatory actions will be taken against you due to a complaint.

The effective date of this notice is March 7, 2021.

Consent to use and disclose your health information

This form is an agreement between, _____, and Excel Social Services Inc. (ESS). When we refer to the word “you”, it can apply to you, your child, a relative, or other person if the name is written here _____.

When ESS examine, test, diagnose, treat, provide services, or refer you to another provider, we will be collecting what the law refers to as Protected Health Information (PHI). We will use this information to decide on treatment/services to provide and to be able to provide you treatment/services. ESS is also able to use and share this information with others who provide you treatment or to arrange payment for the treatment/services we provide or other business functions.

By signing below, you agree to let me use this information here and send it to others such as your insurance company. The Notice of Privacy Practices explains in more detail your privacy rights and how ESS can use and disclose your information. Please make sure to read this notice before signing this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, ESS cannot treat you.

In the future, ESS may change how we use and share your information so ESS may change our Notice of Privacy Practices. If we do so, we will provide you an update copy.

If you are concerned about some of your information, you have the right to ask me not to share some of your information for treatment, payment, or administrative purposes and will need to tell me what you want in writing. ESS will try to accommodate your requests; however, we are not required to agree to these limitations, but if we do agree, we will honor our agreement unless we are unable to by law.

After you have signed this request, you can revoke your consent by writing a letter to ESS informing us of your wishes. We will comply with your request from that point forward but will be unable to change or revoke the information that has already been shared. Please be aware that if you revoke your consent, ESS will be unable to continue providing treatment or services to you.

I have been provided a copy of the Notice of Privacy Practices on _____

Client Name: _____

Client Signature: _____

Date: _____

Parent/Client Representative Name: _____

Parent/Client Representative Signature: _____

Relationship to client: _____ Date: _____

Clinician Name: _____

Clinician Signature: _____ Date: _____

(If applicable, i.e., couple/family therapy)

Client Printed Name: _____

Client Signature: _____ Date: _____

Clinician Printed Name: _____

Clinician Signature: _____ Date: _____