RACHEL MARKS, PSY.D.
Clinical Psychologist

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 READ IT CAREFULLY.

I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am committed to protecting the privacy and security of Personal Health Information concerning my clients. This policy is designed to assure my compliance with all applicable federal and state laws and regulations that require an individual's personal health information to be kept confidential and private. I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I created or received about your past, present, or future mental health or condition, the provision of mental health care to you, or the payment of this mental health care. I must provide you with this Notice about privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within it's practice; PHI is "disclosed" when it is released, transferred, have been given to, or is otherwise divulged to a third party necessary to accomplish the purpose for which the use or disclosure is made. I am legally required to follow the privacy practices described in this Notice.

I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to policies, I will promptly change this Notice and post a new copy of it in the office and on my website. You can also request a copy of this Notice from me, or you can view a copy of it in my office.

I. USE AND DISCLOSURE OF YOUR PHI.

I may use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with examples that may occur in each category.

I can use and disclose your PHI **without your consent** for the following reasons:

A. For Treatment. I can disclose your PHI to physicians, psychiatrists, psychologists, and my own health care providers who provide you with health care services or are involved in your care. For example, if you are being treated by one of my couple's therapists, I can disclose your PHI to this clinician in order to coordinate your care.

Many patients are seen by more than one therapist, whether in groups, individual or in couple counseling. It is often necessary for these therapists to mutually consult regarding your case so that they may best address your needs. Please be aware that these consultations are made in strictest confidence and do not extend to other patients, family members or uninvolved persons.

B. To Obtain Payment for Treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by I to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to billing companies, claims processing companies, and others that process my health care claims.

Patients who are attempting to obtain reimbursement from their insurance company should be aware that the insurance provider might request information from me. Information requested by insurance companies is generally limited to diagnosis and dates of service. Some insurance companies require pre-certification and others will only authorize ongoing treatment based on medical necessity. I will not discuss your case without your prior authorization and written consent. I will review any information exchanges with you prior to the event whenever possible.

C. For Health Care Operations. I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountants or attorneys, to make sure I am complying with applicable laws.

D. Marketing and Outreach
I may contact you for marketing purposes or fundraising purposes, as described below unless you request otherwise:
Example:

I may send you a newsletter and/or calendar of upcoming events. I may also contact you by phone to remind you about upcoming workshops or lectures within the community, which I think may benefit your treatment.

Phone calls go with the territory of my work. I will always try to be available to you for emergencies and can be paged if the need arises. For non-emergency calls, I will contact you as soon as I can. Excessive odd calls are subject to fees comparable to office visits. There may be times when a message may not reach me. If a significant amount of time passes and I have not returned your call, please try reaching me by pager again.

I understand that the demands of work or family can make it difficult to schedule appointments. I will do my best to accommodate difficult or unusual scheduling requests wherever possible. Individual sessions are typically 45 minutes in length, group therapy typically 1.5 hours in length.

E. Change of Ownership
In the event that I sell or merge with another organization, your health information/record will become the property of the new owner.

F. Other Uses and Disclosures, Which Do Not Require Your Consent. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal; state or local law; judicial or administrative proceedings; or law enforcement. I may make a disclosure to applicable officials when a law requires us to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding. If any health professional have reason to believe that a child, minor or dependent adult is being abused, molested, or neglected, the law mandates that I contact the appropriate authorities and file a report as soon as possible. Further, if you are using confidentiality as a means of avoiding legal punishment, privilege is waived.

2. For public health activities. For example, I may have to report information about you to the county coroner.

3. For health oversight activities. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

4. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.

5. To avoid harm. In order to avoid a serious threat to the health or safety of a person, yourself or the public, I may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm, under a mandated reporter. I am bound by the laws to contact the person(s) involved and warn them of possible danger.

6. For specific government functions. I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.

7. For workers' compensation purposes. I may provide PHI in order to comply with workers' compensation laws.

8. Appointment reminders and mental heath related benefits or services. I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other mental health care services or benefits I offer.

9. I may also disclose your PHI to others without your consent if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with us (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you Ire able to do so.

G. Uses and Disclosures Which Require You to Have the Opportunity to Object: I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment of you health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

H. Uses and Disclosures, Which Require Your Prior Written Authorization. In any other situation not described in sections above, I will ask for your authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.

II. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI.

The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but is not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

A. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request as long as I can easily provide the PHI to you in the format you requested.

B. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, the reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI.

C. The Right to Get a List of the Disclosures I Have Made. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operation, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 14, 2003.

I will respond to your request for an accounting of disclosures within 5 business days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you $25.00 fee for each additional request.

D. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and the reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by I, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

E. The Right to Get This Notice by E-mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

III. Other Policies Regarding PHI and Treatment.

I do not provide medications. I will be glad to make a referral to an appropriate medical doctor or psychiatrist should this be requested or indicated. Patients are asked to notify their therapist of their intention to terminate therapy at least one week in advance. This will allow me an opportunity to discuss and provide appropriate discharge recommendation. Individual sessions are typically 50 minutes in length, Group Therapy is 1.5-2 hours. My policy is that I am to be notified at least 24 hours in advance if rescheduling is necessary. Sessions missed without 24 hours notice require payment.

IV. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section V below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about its privacy practices.

V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

I am required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, need to file complaint, or if you want more information about your privacy rights, please contact: Dr. Rachel Marks at (424) 284-8799. If Dr. Rachel Marks is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

VI. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PLEASE READ MY NOTICE OF PRIVACY PRACTICES BEFORE SIGNING THIS FORM. The notice explains my practices related to safeguarding your privacy of your health information, how I use or disclose it, and how you can see it. If you do not agree with my privacy practices, many of which are required by law, I cannot treat you.

By my signature below I, _____, acknowledge that I have had a chance to read a copy of the Notice of Privacy Practices for the office of Rachel M. Marks, Psy.D, Licensed Psychologist.

I understand that if I have any questions regarding this notice or my privacy rights, I can contact Dr. Rachel Marks.

- ❏ I refuse to accept the terms. I understand you cannot provide services as a result.
- ❏ I agree to accept the terms. I consent to service being provided.

_____ _____
Signature of Client Date

_____
Printed Name

_____ _____
Signature of Client's Personal Representative(if other than client) Date

_____
Printed Name

Description of Personal Representative's Relationship to Client (for example, parent or guardian):

_____
_____

Date Notice of Privacy Practices was Given _____/_____/_____
Date

Person seeking services refused to acknowledge receipt.

_____
_____

Dr. Rachel Marks Signature:_____ Date:_____

10436 Santa Monica Blvd., Suite 3005, Los Angeles, CA 90025
424.284.8799 | drrachelmarks@gmail.com

RACHEL MARKS, PSY.D.
CLINICAL PSYCHOLOGIST

I _____ consent to and authorize mental health services by Rachel Marks, Psy.D
(print name)
on _____.
(date)

All sessions and their content will be considered confidential and will not be shared with any outside party without your prior written consent to do so and/or by signing the consent form provided, excluding consultation with other mental health treating individuals related to your treatment. In that case, your name remains anonymous.

Exceptions to confidentiality are in cases of child (under 18), elder (65+), and dependent adult abuse and neglect (18-64), or potential self-harm or harm to others.

I understand that in case of non-payment on my account, some of my information may be disclosed to collection agencies in order to collect the money due. I understand that if it is necessary to cancel an appointment I must give at least 48 hours notice. If notice is not given 48 hours prior to appointment time, I understand that I will be charged the *FULL* fee for the missed appointment.

My signature below represents that I have read and agree with all of the above contents.

_____ _____

Client's Signature Date

10436 Santa Monica Blvd., Suite 3005, Los Angeles, CA 90025
424.284.8799 | drrachelmarks@gmail.com