MARYLAND NOTICE FORM

Notice of Therapist's Policies and Practices to Protect the Privacy of Your Patient's Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *written authorization*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment, and Health Care Operations*"
- *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
- *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my practice group, such as releasing, transferring, or providing access to information about you to other parties.
- "*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes out-side of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reason to believe that a child has been subjected to abuse or neglect, I must report this belief to the appropriate authorities.
- *Adult and Domestic Abuse* – I may disclose protected health information regarding you if I reasonably believe that you are a victim of abuse, neglect, self-neglect or exploitation.
- *Health Oversight Activities* – If I receive a subpoena from the Maryland Board of Examiners of Psychologists because they are investigating my practice, I must disclose any PHI requested by the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If you communicate to my a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *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. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process for PHI.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide notice to you of the changes at your first appointment following the change or by mail. A copy of the most current Policies and Practices to Protect the Privacy of Patient's Heath Information will also be posted on my Website *at www.hawkins-heitt.com*.

V. Questions and Complaints

- If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Dr Sandra Hawkins-Heitt, 8 Reservoir Circle, Suite 105, Baltimore, MD 21208.
- If you believe that your privacy rights have been violated and wish to file a complaint with Dr Hawkins-Heitt, you may send your written complaint to Dr Hawkins-Heitt, 8 Reservoir Circle, Suite 105, Baltimore, MD 21208. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.
- You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

- This notice went into effect on April 14, 2003
- I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by giving you a copy of the revised notice at a session with you or by mailing you a copy of the revision.

Sandra Hawkins-Heitt, PsyD, PA

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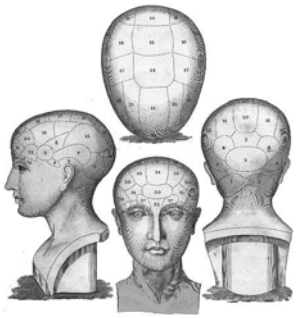

SUMMARY OF AGREEMENT

_____ I understand that Dr Hawkins-Heitt requires 48 hours advance notice of cancellation or I (not my insurance company) will be billed for the session.

_____ I understand payment of fees is required at the time of the visit for out of network services. Dr Hawkins-Heitt will provide me with a monthly statement with the necessary insurance information I may use in order to be reimbursed. If requested, Dr Hawkins-Heitt will complete any outpatient treatment plans necessary in order for me to receive my maximum out of network benefits.

_____ I understand that co-payments are due at the time of service for in network service. Based upon information I have supplied, or Dr Hawkins-Heitt has received, from my insurance company, the estimate of my financial liability for authorized outpatient mental health services are listed below. Dr Hawkins-Heitt is not responsible for the accuracy of the information supplied by me or my insurance company.

$ _____ for the Initial Visit
$ _____ for Visits # 2 through Visit # _____
$ _____ for Visits # _____ through Visit # _____

$ _____ is my annual deductible based upon a calendar year or plan year.
_____ is the annual renewal month of my deductible.

Check here if you have received outpatient mental health treatment in the past as your previous use of mental health benefits may affect your lifetime maximum benefits.

_____ I understand that if my insurance company pays the claim differently than this estimate, I will be liable for the balance that is due.

_____ I understand that I may be required to obtain authorization for mental health services; I should do so by contacting my insurance company.

_____ I understand that if I am unable to reach Dr Hawkins-Heitt directly in case of emergency, I should follow the emergency contact instructions on her voicemail and/ or I should contact the nearest emergency room.

_____ I understand that services provided by Dr Hawkins-Heitt are confidential with the exceptions listed in the Psychologist-Patient Services Agreement.

My signature below indicates that I have read and understood this agreement and I agree to its terms and it also serves as an acknowledgement that I have received the HIPAA notice form described above.

_____ Patient Signature

_____ Therapist Signature

_____ Date

_____ Date