



**Fingerprints Family
Therapeutic Services**

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed, and how you are able to access this information. Please review it carefully.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

Protecting our clients' privacy is important to this practice. A new federal and state law entitled the Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14, 2003 and requires us to inform you of our policy. At Ellie Mental Health, we are very careful to keep your health information secure and confidential.

This law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a physician specialist, with whom we may involve in your care plan.

This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights with the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every



**Fingerprints Family
Therapeutic Services**

use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations we may use or disclose your health information for payment for your services. For example, we may send a report of your progress to your health insurance company. We may disclose your health information for our normal healthcare operations. For example, one of our staff members will enter your information into our computer. We may share your medical information with our business associates, such as a billing representative or service. We have a written contract with each business associate which requires them to protect your privacy.

Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. We may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also want to call and remind you about appointments. If you are not home, we may leave this information on your answering service or with the person who answers the telephone unless you have instructed us otherwise. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

Lawsuits and Disputes: If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.



Fingerprints Family

Therapeutic Services

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. We do keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
 - a. For use in treating you.
 - b. For use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
 - c. For use in defending myself in legal proceedings instituted by you.
 - d. For use by the Secretary of Health and Human Services to investigate compliance with HIPAA.
 - e. Required by law and the use or disclosure is limited to the requirements of such law.
 - f. Required by law for certain health oversight activities about the originator of the psychotherapy notes.
 - g. Required by a coroner who is performing duties authorized by law.
 - h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. We will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. We will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, we can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on our premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence



Fingerprints Family

Therapeutic Services

operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, we may provide your PHI in order to comply with workers' compensation laws. 10 Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and we may say "no" if we believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How we Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures we Have Made. You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list



Fingerprints Family

Therapeutic Services

we will give you will include disclosures made in the last six years unless you request a shorter time. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost-based fee for each additional request.

6. 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 from your PHI, you have the right to request that we correct the existing information or add the missing information. We may say “no” to your request, but we will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

CLIENT NOTICE FOR FILING A COMPLAINT

The nature of the services provided by Fingerprints Family Services are voluntary. If at any point in the relationship with your provider you are unhappy or feeling uncomfortable, you are encouraged to first contact Fingerprints Family Services Director of Clinical Operations to talk about your concerns.

You may file a complaint with Texas Health and Human Services by calling 2-1-1 or 877-541-7905, toll-free, or in writing to HHS Privacy Division, P.O. Box 149030, Mail Code 1355 Austin, TX 78714. You also may file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, Region VI, 1301 Young St., Suite 1169, Dallas, TX 75202

If you believe that your privacy has been compromised or if you are seeking more assistance regarding your personal health information, we ask that you first contact Fingerprints Family Services, LLC Director of Clinical Operations at 832-929-4445 or via email at fingerprintsfamilyservices@gmail.com.

RELEASE OF RECORDS

All client information is considered strictly confidential (subject to limitations authorized or required by law) and will not be given out to anyone without your prior written consent or other legal authorization. In the event of a request for copies of or a transfer of client records, the records will be forwarded only after receipt by Fingerprints Family Services, LLC of proper signed written authorization from the client or other authorized persons. Please note that email and text communication is not secure and therefore confidentiality cannot be guaranteed.



Fingerprints Family Therapeutic Services

RECORDING

Fingerprints Family Services does not permit the audio, video or other electronic recording of any services provided without the express written permission of an authorized representative of Fingerprints Family Services. Any violation of this policy may result in immediate termination of the services being provided.

AFTER-HOURS EMERGENCIES

Fingerprints Family Services providers are not available for after-hours emergencies. Messages are checked weekdays during the hours of 8:00 am and 5:00 pm. To leave a message, call your provider directly or call our administrative office. For after-hours emergencies or if you need immediate assistance, call 911, your medical group or primary care physician.

Here are some crisis phone numbers:

- **NATIONAL SUICIDE PREVENTION LIFELINE: 1-800-273-8255 (TALK)**
- **Westpark Springs IOP/PHP/Emergency services: 832-586-8569**
- **Houston Behavioral Hospital: 832-834-7710**
- **Cinco Ranch Behavioral Health: 281-665-7346**
- **Texana Center: 281-239-1300**
- **Crisis Intervention Hotline: 832-416-1177**
- **Crisis Intervention Call/TEXT(TEEN): 832-416-1199**
- **Crisis Intervention (TEEN): 281-201-4430**
- **Oceans Behavioral Hospital: 281-492-8888**

CLIENT RIGHTS AND CONSENT FOR SERVICES

Fingerprints Family Services does not discriminate based on race, color, national origin, creed, religion, sexual orientation, public assistance status, marital status, age, disability, or sex, including sex stereotypes and gender identity.

Acknowledgement of Receipt of Privacy Notice

I have read and understand the above policies. I further understand that the information I have furnished is to be used for management purposes and the agency will ensure confidentiality. I may inquire about or object to the methods and/or type of information stored. My rights are protected under



Fingerprints Family
Therapeutic Services

the State and Federal Confidentiality laws and any release of information requires my consent except where required and permitted by law, including child abuse and/or neglect and the intent to harm others or myself. I give my consent to Fingerprints Family Services, LLC to provide evaluation, treatment and/or other services that we mutually determine to be appropriate. I am participating voluntarily and I understand my right to refuse or discontinue treatment at any time. I have had the opportunity to discuss my reasons for seeking services and I understand my responsibilities in the therapeutic relationship.