NOTICE OF PRIVACY PRACTICES

Crystal Hemesath, LMFT, LMHC
6600 Westown Parkway, Suite 240, West Des Moines, IA 50266

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

I am a mental health care provider. More specifically, I am a Licensed Marriage and Family Therapist and Licensed Mental Health Counselor licensed by the State of Iowa through the Board of Behavioral Sciences.

I am required by federal law to maintain the privacy of your medical information, also known as protected health information "PHI" and to give you my Notice of Privacy Practices (this "Notice") that describes my privacy practices, legal duties and your rights concerning your medical information. Except where such use or disclosure is otherwise prohibited by state or federal law, I am permitted or required to use or disclose your protected health information without your authorization (permission) in the following situations.

Ways in Which I May Use and Disclosure Your Protected Health Information Without Your Authorization:

The following paragraphs are examples of when such disclosures may or will be made in regard to your protected health information.

An example of a use or disclosure for treatment purposes: If I decide to consult with another licensed health care provider about your condition, I am permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist me in the diagnosis or treatment of your mental health condition. I am permitted to use and disclose your protected health information to provide, coordinate, or manage your health care and any related service.

An example of a use or disclosure for payment purposes: I will use and disclose your personal health information to obtain payment for the health care services I provide to you. For example, I may provide your personal health information to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

An example of a use or disclosure for health care operations purposes: If your health plan decides to audit my practice in order to review my competence and my performance, or to detect possible fraud or abuse, your mental health records may be used or disclosed for those purposes. (This could only happen if you utilize your insurance for my services.) In addition, I may disclose your health information to a third party business associate(s) who perform billing, consulting, or other services for my practice.

Other Ways I May Use and Disclosure Your Protected Health Information Without Your Authorization:

1) ***Child Abuse***-If disclosure is compelled by the Child Abuse and Neglect Reporting Law of the geographic location where you reside (for example, if I have a reasonable suspicion of child abuse or neglect). I am a mandatory reporter.
2) ***Elder Abuse or Dependent Adult Abuse***-If disclosure is compelled by the Elder/Dependent Adult Abuse Reporting Law of the geographic location where you reside (for example, if I have a reasonable suspicion of elder abuse or dependent adult abuse). I am a mandatory reporter.
3) ***Disclosure that is Otherwise Specifically Required by Law***-I will use and disclose your protected health information when required to by federal, state, or local law.
4) ***Judicial and Administrative Proceedings***-If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered.
5) ***Serious Threat to Health or Safety***-If I believe you present a clear, imminent risk to a reasonably identifiable victim or victims, I may disclose information necessary to seek hospitalization or otherwise protect that individual. If I believe there is clear and imminent risk that you will harm yourself, I may disclose information necessary to seek hospitalization for you or to alert family members or others who have the ability to protect you.
6) ***Worker's Compensation***-I will disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
7) ***Permission to Contact You*****-**I am permitted to contact you without your prior authorization to provide appointment reminders or information about alternatives or other health-related benefits and services that may be of interest to you.
8) ***More Stringent Laws*****-**Some of your protected information may be subject to other laws and regulations and are afforded greater protection than what is outlined in this Notice. For instance, HIV/AIDS, substance abuse, and mental health information are often given more protection. In the event your protected information is afforded greater protection under federal or state law, we will comply with the applicable law.
9) ***Inmates*****-**I will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

PLEASE NOTE**:** The above list is not an exhaustive list, but informs you of most circumstances when disclosures without your written authorization may be made. Other

uses and disclosures will generally be made only with your written authorization, even though federal privacy regulations or state law may allow additional uses or disclosures without your written authorization. Uses or disclosures made with your written authorization will be limited in scope to the information specified in the authorization form, which must identify the information "in a specific and meaningful fashion." You may revoke such authorization at any time, provided that the revocation is in writing and except to the extent that I have taken action in reliance on your written authorization.

Your Rights Regarding Protected Health Information

1) You have the ***right to request restrictions*** on certain uses and disclosures of protected health information about you, such as those necessary to carry out treatment, payment, or health care operations. I am not required to agree to your requested restriction. If I do agree, I will comply with your request except for emergency treatment.
2) You have the ***right to receive confidential communications*** of protected health information from me by alternative means or at alternative location. 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. Your request must be made in writing and must specify how or where I am to contact you.
3) You have the ***right to inspect and copy*** protected health information about you by making a specific request to do so in writing. This right to inspect and copy is not absolute – in other words, I am permitted to deny access for specified reasons. For instance, you do not have this right of access with respect to my "psychotherapy notes." The term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical (includes mental health) record. The term excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. If you wish to inspect or copy your medical information, you must submit your request in writing to: Crystal Hemesath, 6600 Westown Parkway, Suite 240, West Des Moines, IA 50266, (515) 556-3668. You may mail your request, or bring it to my office. I have 30 days to respond to your request of information.
4) You have the ***right to amend*** protected health information in my records by making a request to do so in a writing that provides a reason to support the requested amendment. This right to amend is not absolute – in other words, I am permitted to deny the requested amendment for specified reasons. You also have the right, subject to limitations, to provide me with a written addendum with respect to any item or statement in your records that you believe to be incorrect or incomplete and to have the addendum become a part of your record.
5) You have the ***right to receive an accounting of disclosures*** from me of your protected health information that I have made outside of my practice that is not for

treatment, payment, or health care operations. As with other rights, this right is not absolute. In other words, I am permitted to deny the request for specified reasons. For instance, I do not have to account for disclosures of protected health information that are made with your written authorization, since you have a right to receive a copy of any such authorization you might sign. You may not request information for any dates prior to six years before your written request (our legal obligation to retain information).

6) You have the ***right to obtain a paper copy*** of this notice from me upon request.

PLEASE NOTE: In order to avoid confusion or misunderstanding, I ask that if you wish to exercise any of the rights enumerated above, that you put your request in writing and deliver or send the writing to me. I am willing to discuss any of these matters with you. As mentioned elsewhere in this document, I am the Privacy Officer of this practice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint. Because I am the Contact Person of this practice, you may contact me, Crystal Hemesath, LMFT, LMHC, 6600 Westown Parkway, Suite 240, West Des Moines, IA, 50266, (515) 556-3668 or directly to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with me, within 180 days of the suspected violation, by simply providing me in writing the manner in which you believe the violation occurred, the approximate date of such occurrence, and any details that you believe will be helpful to me. You will not be penalized or retaliated against for filing a complaint. Complaints to the Secretary must be filed in writing. A complaint to the Secretary can be sent to U.S. Department of Health and Human Services, 601 East 12th Street--Room 248, Kansas City, MO, 64106.

For More Information

If you need or desire further information related to this Notice or its contents, or if you have any questions about this Notice or its contents, please feel free to contact me. As the Contact Person and Privacy Officer for this practice, I will do my best to answer your questions and to provide you with additional information.

This notice first became effective on April 14, 2003; updated January 16, 2011.