The Neuropsychology Center of St. Louis
425 N. New Ballas Rd.
Suite 290
Creve Coeur, MO 63141
314-324-3800

NOTICE

The privacy of your health information is important to me. I will maintain the privacy of your health information and I will not disclose your information to others without your permission, or unless the law authorizes or requires me to do so.

The federal law HIPAA requires that I take additional steps to keep you informed about how I may use the information gathered to provide health care services to you. As part of this process, I am required to provide you with a Notice of Privacy Practices and to request that you sign a written acknowledgement that you received a copy of the Notice of Privacy Practices.

The Notice of Privacy Practices describes how I may use and disclose your protected health information to carry out treatment, or payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights regarding health information that I maintain about you, and a brief description of how you may exercise your rights.

If you have any questions about this notice
Please contact the office at 314-324-3800

What is Protected Health Information?

Protected Health Information is information that relates to:

(1) Your past, present or future physical or mental health or condition;
(2) The provision of health care including mental health care to you;
(3) The past, present, or future payment for the provision of health care including mental health care to you;

And includes

(4) Demographic information that identifies you or that could be used to identify you.

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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 IT CAREFULLY.

I am required by federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I must follow the privacy practices that are described in this Notice, which may be amended from time to time.

For more information about my privacy practices, or for additional copies of this Notice, please contact me using the information listed in Section II G of this Notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

a. Permissible Uses and Disclosures Without Your Written Authorization – I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

i. Payment: I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. For example, I may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

ii. Health Care Operations: I may use or disclose PHI in connection with my health care operations, including quality improvement activities, training programs, accreditation, certification, licensing, or credentialing activities.

iii. Communications: I may use or disclose PHI to contact you regarding missed appointments or if I need to change our appointment time. I may leave messages on your answering machine unless you have directed me otherwise. When we

communicate by cell phone or computer, be aware that the information is not always secure from access by third parties.

iv. Treatment: I may use PHI to diagnose and treat you. I may use PHI to inform you about treatment alternatives or other related topics. I may also use or disclose PHI for clinical coverage during periods of my absence.

v. Required or Permitted by Law: I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. In addition, I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health of safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board;
and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or others as authorized by law.

b. Uses and Disclosures Requiring Your Written Authorization

1. Psychotherapy Notes: Notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and in most cases will not otherwise be used or disclosed without your written authorization.

2. Treatment: I will not use or disclose PHI to other health providers without your written consent.

3. Marketing Communications: I will not use your health information for marketing communications without your written authorization.

4. Other Uses and Disclosures: Uses and disclosures other than those described in this Notice of Privacy Practices will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

a. **Right to Inspect and Copy.** You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. I you are a parent or legal guardian of a minor, please not that certain portions of the minor's medical record will not be accessible to you.

b. Right to Alternative Communications. You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

c. Right to Request Restrictions. You have the right to restrict certain disclosures of Protected Health Information (PHI) to a health plan if you pay out-of-pocket in full for your services.

d. Right to Accounting Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after January 1, 2010. This right applies to disclosures for purposes other than treatment, payment, or health care operations and excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

e. Right to Request Amendment. You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

f. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time.

g. Right to Be Notified. You have the right to be notified if there is breach of your unsecured PHI.

h. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact the designated Privacy Officer Tammy A. Martielli, Ph.D. at 314-324-3800. You may also file written complaints with the Director, Office for Civil Rights of the United States Department of Health and Human Services. I will not retaliate against you if you file a complaint with the Director or myself.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

a. Effective Date. This Notice is effective immediately.

b. Changes to this Notice. I may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in the waiting area of my office. You may also obtain any revised notice by contacting the Privacy Officer.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature, I _____, acknowledge that I received a copy of the Notice of Privacy Practices for The Neuropsychology Center of St. Louis, LLC.

_____ _____
Signature of Client (or personal representative) Date

If this acknowledgement is signed by a guardian, or personal representative of the client,
Please complete the following:

Personal Representative's Name: _____

Relationship to the client: _____

FOR OFFICE USE ONLY
I attempted to obtain written acknowledge of receipt of the Notice of Privacy Practices, but acknowledgement could not be obtained because:
____ Individual refused to sign
____ Communication barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented obtaining the acknowledgement
____ Other (please explain) _____

THIS FORM WILL BE RETAINED IN YOUR MEDICAL RECORD

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