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ACKNOWLEDGMENT OF HIPPAA CCOMPLIANCE

HIPPAA, The Health Insurance Portability and Accountability Act, was enacted by congress to protect your personal health information. It is a set of regulations that guides the way healthcare information is stored and shared. This includes how disclosures are made. It is intended to protect your private medical information. The State of Texas and the Texas State Board of Examiners of Licensed Professional Counselors code of ethics have long established standards which meet and in many cases exceed HIPPAA standards. This office has and will continue to comply with all ethical and legal guidelines in the state of Texas that apply to mental health counseling, and with the newly enacted Federal HIPPAA regulations.

Following are circumstances in which your personal health information may be used:

1. In accordance with HIPPAA, your information may only be released with your express written consent.
2. Your demographic information as well as diagnosis may be used in secure electronic billing. Billing staff is informed of dates of service, diagnosis, your demographic information, and health insurance information. For clients who choose to file insurance claims, please be aware that in order for you to be reimbursed by your health care company, I will be required to diagnose a mental health condition. Any diagnosis made may become a part of your medical / insurance record.
3. All of our sessions will become part of your clinical record. Our communication is privileged. I will keep confidential anything you say to me, with exceptions that include but are not limited to the occurrence of any of the following situations: 1) you authorize me to disclose information to any third party, as in the case of insurance reimbursement or consultation with another professional; 2) I am ordered by a court of law to disclose your information; 3) I determine that you pose a danger to yourself or to others; 4) I become aware of any abuse (physical or sexual) including neglect which involves a child or an aged adult.
4. I will maintain your records for a period of five years (for children this means five years beyond the age of 18). Client files are stored in dual-lock storage. All electronic data is password protected.
5. In the event that I am unable to collect payment for services rendered within 180 days and no payment plan or alternative arrangement can be agreed upon, know that your demographic information, the date(s) of service, and information concerning the type(s) of service provided will be given to a professional collection agency.
6. When requesting additional authorizations from your insurance company (particularly HMO's), I will quite likely be required to support my request with clinical information.
7. To ensure that I am providing quality care, insurance companies may from time to time audit my files. In the event of an audit, an agent of the insurance company may request access to your file in order to verify the presence of essential paperwork (such as initial assessment, visitation log, demographic information, client contract, explanation of confidentiality, treatment plan, and discharge notes.)

8. I may hire a medical professional to audit my files in preparation for outside audits or to provide support services as needed. Outside of this, no other 'Quality Improvements' will be performed on your file by anyone other than myself. Any business agent, such as a medical billing service, medical secretary, or auditor is bound to strict confidentiality and is punishable by law for any infringement upon confidentiality clauses.

Thank you for choosing me as your therapist. I appreciate your trust and the opportunity to work with you. If you have any questions, please feel free to speak with me directly. Always ask questions! Once you have read and have an understanding of the above information on health insurance claims and HIPPAA, please sign and date below. If you have any further questions regarding HIPPAA you may visit www.hhs.gov/ocr/hippaa or call directly 1.800.627.7748. You may also email questions to: ocrprivacy@os.dhhs.gov

_____	_____
Signature of Client / Legal Guardian	Date
_____	_____
Printed Name	Relationship to Client