Affirmative Transformation Services, LLC

Notice of Privacy Practices

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

This Notice of Privacy Practices describes how Affirmative Transformation Services, LLC may use and disclose your protected health information (PHI) for purposes of treatment, payment and health care operations, and for other purposes that are permitted or required by law.

I. OUR RESPONSIBILITIES:
We take the privacy of your / your child's health information seriously. We are required by law to maintain the privacy of your health information and provide you with this Notice of Privacy Practices. We will abide by the terms of this Notice of Privacy Practices. We reserve the right to change this Notice of Privacy Practices and to make any new Notice of Privacy Practices effective for all protected health information that we maintain. When this notice is updated, Affirmative Transformation Services, LLC, will post a notification on our website and in the waiting room of each location. You can ask your clinician for a copy of the most current notice at your next appointment or call the office at 478-227-6144 for a copy.

II. WHAT IS "PROTECTED HEALTH INFORMATION" (PHI)?
Protected health information (PHI) is demographic and individually identifiable health information that will or may identify the patient and relates to the patient's past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF INFORMATION
Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations.

III. WHAT DOES "HEALTH CARE OPERATIONS" INCLUDE?
Health care operations include activities such as communications among health care providers, conducting quality assessment and improvement activities; evaluating the qualifications, competence, and performance of health care professionals; training future health care professionals; other related services that may be a benefit to you such as case management and care coordination; contracting with insurance companies: conducting medical review and auditing services; compiling and analyzing information in anticipation of or for use in legal proceedings; and general administrative and business functions.

IV. HOW IS MEDICAL INFORMATION USED?

We use medical records as a way of recording health information, planning care and treatment, and as a tool for routine health care operations. Your insurance company may request information such as procedure and diagnosis information that we are required to submit to bill for the treatment we provide to the patient. Other health care providers or health plans reviewing your records must follow the same confidentiality laws and rules required of us. Patient records are also a valuable tool used by researchers in finding the best possible treatment for diseases and medical conditions. All researchers must follow the same rules and laws that other health care providers are required to follow to ensure the privacy of patient information. Information that may identify patients will not be released for research purposes to anyone without written authorization from the patient or the patient's parent or legal guardian.

V. HOW MEDICAL INFORMATION MAY BE USED FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

Medical information may be used to justify needed patient care services (i.e., lab tests, prescriptions, treatment protocols).

We will use medical information to establish a treatment plan.

We may disclose protected health information to another provider for treatment (i.e., referring physicians, specialists, and providers, therapists, etc.)

We may submit claims to your insurance company containing medical information, and we may contact their utilization review department to receive pre-certification (prior approval for treatment). We will submit only the minimum amount of information necessary for this purpose.

We may use the emergency contact information you provided to contact you if the address of record is no longer accurate.

We may contact you to remind you of the patient's appointment by an automated call, text, or email. We may contact you to discuss treatment alternatives or other health-related benefits that may be of interest.

Minors - If you are an unemancipated minor under Colorado law, there may be circumstances in which we disclose health information about you to a parent or guardian in accordance with legal and ethical responsibilities.

Parents - If you are a parent of an unemancipated minor, and are acting as the minor's representative, we may disclose health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's representative in order for your child to receive care from us, we may disclose health information about your child to you.

In some circumstances, we may not disclose health information about an unemancipated minor to you. For example, if your child is legally authorized to consent to treatment (without separate consent from you), consents to such treatment, and does not request that you be treated as his or her personal representative, we may not disclose health information about your child to you without your child's authorization.

VI. WHY DO I HAVE TO SIGN A CONSENT FORM?
When you, as the patient or the parent or guardian of a patient, sign a consent form, you are giving us permission to use and disclose protected health information for the purposes of treatment, payment and health care operations. In some instances, this permission does include psychotherapy notes, psychosocial information, alcohol, and drug abuse treatment records. You must specify what type of PHI you do and do not want released. You will need to sign a separate authorization to have protected health information released for any reason other than treatment, payment, or healthcare operations.

VII. WHAT ARE PSYCHOTHERAPY NOTES?
Psychotherapy notes are notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session that are separated from the rest of the patient's medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, 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.

VIII. WHAT IS PSYCHOSOCIAL INFORMATION?
Psychosocial information is information provided regarding your family's social history and counseling services you have received.

IX. WHY DO I HAVE TO SIGN A SEPARATE AUTHORIZATION FORM?
In order to release patient protected health information for any reason other than treatment, payment and health care operations, we must have an authorization signed by the patient or the parent or guardian of the patient that clearly explains how they wish the information to be used and disclosed.
The following are some examples of releases of information that require a separate authorization:

- Psychotherapy Notes
- Psychosocial information
- Use of information in scientific and educational publications, presentations, and materials.

X. CAN I CHANGE MY MIND AND REVOKE AN AUTHORIZATION?
You may change your mind and revoke an authorization, except (1) to the extent that we have relied on the authorization up to that point, (2) the information is needed to maintain the integrity of the research study, or (3) if the authorization was obtained as a condition of obtaining insurance coverage. All requests to revoke an authorization should be in writing.

XI. SHARING INFORMATION WITH BUSINESS ASSOCIATES

There are some services provided through contracts with business associates. Examples include billing services, electronic medical records, laboratory, and transcription services. When these services are contracted, we may disclose your health information to the business associate so that they can perform the job we have contracted them to do.

XII. WHEN IS MY AUTHORIZATION / CONSENT NOT REQUIRED?

The law requires that some information may be disclosed without your authorization in the following circumstances:

- In case of a clinical emergency
- When there are communication or language barriers
- When required by law
- When there are risks to public health
- To conduct health oversight activities
- To report suspected child abuse or neglect
- To specified government regulatory agencies
- In connection with judicial or administrative proceedings
- For law enforcement purposes
- To coroners, funeral directors, and for organ donation
- In the event of a serious threat to health or safety

XIII. YOUR PRIVACY RIGHTS

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

1. You have the right to inspect and copy your health information.

This means you may inspect and obtain a copy of your PHI that is contained in a designated record set for so long as we maintain the PHI. A designated record set contains medical and billing records and any other records that we use in making decisions about your healthcare. You may not, however, inspect or copy the following records: psychotherapy and psychosocial notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and certain PHI that is subject to laws that prohibit access to that PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have the right to have this decision reviewed. Please contact our Clinical Director if you have questions about access to your medical record.

2. You have the right to request a restriction of your health information.

This means you may ask us to restrict or limit the medical information we use or disclose for the

purposes of treatment, payment, or healthcare operations. We are not required to agree to a restriction that you may request. We will notify you if we deny your request. If we do agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting our Clinical Director. If you pay out of pocket for services, you have the right to request that we not disclose PHI related solely to those services in which you paid out of pocket.

3. You have the right to request to receive confidential communications by alternative means or at alternative locations.

We will accommodate reasonable requests. We may also condition this accommodation by asking you for an alternative address or another method of contact. We will not request an explanation from you as the basis for the request. Requests must be made in writing to our Clinical Director.

4. You have the right to request amendments to your health information.

This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with our Clinical Director and we may prepare a rebuttal to your statement and will provide you with a copy of this rebuttal. If you wish to amend your PHI, please contact our Clinical Director. Requests for amendment must be in writing.

5. You have the right to receive an accounting of disclosures of your health information.

You have the right to request an accounting of certain disclosures of your PHI. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, to family or friends involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Clinical Director. The request should specify the time period sought for the accounting. Accounting requests may not be made for periods of time in excess of six years.

6. You have the right to receive a paper copy of this Notice of Privacy Practices.

This notice can be printed out by you from our patient portal, or you may sign on using your login information anytime to review the notice. If you have difficulty with this contact the office to request a copy is printed out for you.

7. You have the right to be notified if there is a breach in your PHI.

If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

8. You have the right to opt-out of fundraising communications.

If we send any fundraising communications, you have the right to opt-out of receiving these. To do so, contact the office to make this request

XIV. WHAT IF I HAVE A QUESTION / COMPLAINT?

If you have questions regarding your privacy rights, please contact Dr. Yolanda King, PsyD, LPC, at Affirmative Transformation Services, LLC. If you believe your privacy rights have been violated, you may file a complaint by contacting Dr. Yolanda King, PsyD, LPC, or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

The address for the Secretary of the Department of Health and Human Services is:
Office of Civil Rights
U.S. Department of Health and Human Services Atlanta
Federal Center
Suite 3B70 61 Forsyth St., S.W.
Atlanta, GA 30303-8909
(404) 562-7886 (phone)
(404) 562-7881 (fax)
(404) 331-2867 (TDD)
www.hhs.gov/ocr/hipaa

By signing this electronically, I acknowledge that I received this notice and fully understand the HIPAA law.

_____
Signature of Patient/Personal Representative/Parent of Minor

_____
Printed Name of Patient/Personal Representative/Parent of Minor

Date _____

Description of Personal Representative's Authority: _____