

**Washington Falls Psychotherapy and Consultation**  
**405 N. Washington St., Suite 104**  
**Falls Church, VA 22046**  
**703-533-9433 (fax)**

**HIPAA "Notice of Privacy Practice"**  
**Informed Consent**

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS  
AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED,  
AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.  
PLEASE REVIEW IT CAREFULLY.

As a rule, I will disclose no information obtained from your contacts with me, or the fact that you are my patient, except with your written consent. However, there are some important exceptions to this rule of confidentiality - some exceptions created voluntarily by my own choice and some required by law. If you wish to receive mental health services from me, then under the Federal HIPAA regulations, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits.

**I. Uses and Disclosures Requiring Authorization or Consent**

HIPAA allows health care providers to use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes. **In my own practice however, I do not disclose information routinely in these circumstances, so this will require your permission in advance, either through your consent at the onset of our relationship** (by signing the attached general consent form), **or through your written authorization at the time the need for disclosure arises.** You may revoke your permission to release PHI, in writing, at any time, by contacting me. If there is an emergency and I cannot ask your permission, I am allowed to share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you

**II. Possible Uses and Disclosures with Neither Consent nor Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances by policy, or if legally required:

- **Child Abuse Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by Virginia law to report the matter immediately to the Virginia Department of Social Services.
- **Adult Abuse Reporting:** If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Virginia law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.
- **Health Oversight:** Virginia law requires that I report misconduct by a health care provider of my own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report that you are in treatment if I believe that your condition places the public at risk. Virginia Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.
- **Court Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without your written authorization, or if a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court. In Virginia, parents' therapy records may not be used as evidence (i.e., are privileged) in child custody cases, but a child's records do not have that same protection. In civil court cases, therapy information or records are not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, Virginia has no statute granting therapist-patient privilege, although records can sometimes be protected on another basis. Protections of privilege also do not apply if I do an evaluation for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** Under Virginia law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety.
- **Workers Compensation:** If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.
- **Records of Minors:** Virginia has a number of laws that allow access to the records of minors without consent. These include: parents, regardless of custody; CSB evaluators in civil commitment cases; Court-Appointed Special Advocates in child abuse or neglect procedures, if the court so orders; and Protective Services Workers to whom I have reported suspicion of abuse or neglect, if they so request.
- **Consultations:** To ensure that I am providing quality care, I meet regularly with a peer consultation group. I do not reveal identifying information. I will provide the names of my peer consultants on request.

- **Vacations:** When I am away from the office for extended periods of time, a colleague may cover for my practice and take emergency calls. If s/he will need information to assist you in my absence, I will provide it without using your full name; you and I will discuss the plan first.
- **Third Party Payers:** If you wish to obtain third party reimbursement for mental health services, certain information must be provided. You must decide whether to give consent to me to release the necessary information to an insurance company (or any other third party payer) in order to receive reimbursement. Initially, that usually involves providing information about dates of treatment, type of treatment, and diagnosis. If I receive requests for further information, these will be discussed with you before information is provided.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

### III. Definitions

To help clarify the terms, here are some definitions:

- **"PHI" (Protected Health Information)** refers to information in your health record that could identify you.
- **"Treatment, Payment and Health Care Operations"** --Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of a disclosure related to treatment would be when I consult with another health care provider, such as your PCP or psychiatrist. --Payment is when I obtain reimbursement for your healthcare. Examples of disclosure for payment purposes are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. --Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. **NOTE:** In this office my colleagues do not have access to my records.
- **"Use"** applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **"Disclosure"** applies to activities outside of my office, such as releasing, transferring or providing access to information about you to other parties.
- **"Consent"** is a general permission that allows me to use and disclose your health care information for routine purposes of treatment, payment and operations. For example, under the law, you must sign this consent form before I can begin to see you for therapy or provide other mental health services.
- **"Authorization"** is required by law and involves your written permission to use and disclose information not covered by the consent form. There are a few cases (see above) in which I am allowed, even required, to use and disclose your information without your consent or authorization. I will keep a record of disclosures, and this will be available to you.

### IV. Patient's Rights and Provider's Duties:

- **Right to Request Restrictions**-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** -- You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.
- **Right to an Accounting of Disclosures** - You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process
- **Right to Inspect and Copy** - In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.
- **Right to Amend** - If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.
- **Right to a copy of this notice** - You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE: 5/1/2006

**Linda Peterson Rogers, Ph.D., R.N., LMFT  
Individual, Couple & Family Psychotherapy  
AAMFT Clinical Member & Supervisor  
Certified EFT Therapist & Supervisor  
405 N. Washington St., Suite 104  
Falls Church, VA 22046  
703-241-4151 (phone)  
703-533-9433 (fax)**

**Patient's Acknowledgement of  
Receipt of Notice of Privacy Practices and Consent to Treatment**

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of the "notice of privacy practices" that will apply to services provided by Dr. Linda Peterson Rogers.

I consent to these policies as a condition of receiving services.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_