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**Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health**

**Information**

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION

ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION ACCORDING TO THE HEALTH INSURANCE PORTABILITY ACT OF 1996 (HIPAA). PLEASE REVIEW IT CAREFULLY.

I may *use* or *disclose your protected health information (*information in your health record that could identify you or PHI), for *treatment, payment, and health care operations* purposes with your *consent.*

**I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

*“PHI”* 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 treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

*“Payment”* is when I obtain reimbursement for your healthcare. Examples of payment 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.

*"Use"* applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

*"Disclosure"* applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

**II. Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes.

*"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing.

You may not revoke an authorization to the extent that (1)1 have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

I will also obtain an authorization from you before using or disclosing:

· PHI in a way that is not described in this Notice.

· Psychotherapy notes

· PHI for marketing purposes, such as sending a list or newsletter of helpful services to my clients

**III. Uses and Disclosures with Neither Consent nor Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:

**Child Abuse:** If I have a reason to suspect that a child has been abused or neglected, I am required by law to report this to the Bureau of Child and Family Services.

**Adult and Domestic Abuse:** If I suspect or have a good faith reason to believe that any incapacitated adult has been subject to abuse, neglect, self neglect or exploitation, or is living in hazardous conditions, I am required by law to report that information to the Commissioner of the Department of Health and Human Services.

**Health Oversight:** If the Maine Board of Psychological Examiners is conducting an investigation, then I am required to disclose your mental health records upon receipt of a subpoena from the Board.

**Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I provided you and/or the records thereof, such information is privileged under state law, and I may not release information without your written authorization, 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. You will be informed in advance, if this is the case.

**Serious Threat to Health or Safety:** If you have communicated to me a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims, or if you have made a serious threat of substantial damage to real property, I am required by law to take reasonable precautions to provide protection from such threats by warning the victim or victims of your threat and to notify the police department closest to your residence or the potential victim's residence, or obtain your civil commitment to the state mental health system.

**When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and Maine’s confidentiality law**: This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDG-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

**IV. Patient's Rights and Psychologist's Duties**

Patient's Rights:

*Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

*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.)

*Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.

*Right to Amend -* You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

*Right to an Accounting-* 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 request, I will discuss with you the details of the accounting process.

*Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

*Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket* - You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

*Right to Be Notified if There is a Breach of Your Unsecured PHI* - You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Psychologist's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will post a current copy of this Notice in my office and will provide you with a paper copy with the new effective date on request.

**V. Complaints**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the Office for Civil Rights, which can be reached at (617) 565-

1340. You may also send a written complaint to the Secretary of the U.S. Department of Health and

Human Services.

**VI. Restrictions and Changes to Privacy Policy**

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain.

**VII. Electronic Payment Communication Disclosure**

If you wish, you may pay fees electronically – through funds transfer or using a payment card -- using any of the following services:

* *Visa, MasterCard, Discover, American Express*
* *Health Savings Account & Health Spending Accounts*
* *PayPal*
* *PayPal Here*

**Please Be Aware of the Following:** I have a duty to uphold your confidentiality under HIPAA , and thus I wish to make sure that your use of the above payment services is done as securely and privately as possible.

After using any of the above services to pay your fees, that service may send you receipts for payment by email or text message. These receipts will include my business name, and would indicate that you have paid for a therapy session. Although I will ask you if you want a receipt and how you wish to get it, it is possible that the receipt may be sent automatically, without first asking if you wish to receive the receipt. I am unable to control this in many cases, and I may not be able to control which email address or phone number your receipt is sent to. I am happy to provide you with a paper receipt for your records or for insurance purposes if you require a receipt.

**Health Savings Accounts and Flexible Spending Accounts**

If you are using a Health Savings Account (HSA) or Flexible Spending Account (FSA) payment card, please be aware that even if your payment goes through and is authorized at the time that we run your card, there is a possibility that your payment could later be denied. In the event of this happening, you are responsible for ensuring that full payment is made by other means.

Your signature below indicates that you have read and received a copy of this information.

Client’s Printed Name

Client’s Signature Date

/ /

Printed Name of Parent/Guardian if client is under 18

Parent’s Signature Date

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