



HIPAA INFORMED CONSENT

Background: The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. This is a “friendly” version. A more complete text is posted at the clinic. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. In addition, HIPAA provides certain rights and protects you as a patient. We balance these needs with our goals of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services www.hhs.gov.

Policies

1. Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers, as is necessary and appropriate for your care.
2. Patient files are stored after sessions in locked filing cabinets. However, the normal course of providing care means that such records be left temporarily in administrative areas such as the front office, clinician’s office, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
3. This practice aims to remind clients of their appointments. We may do so by phone, text, or email in the most convenient manner for you. However, it is not our responsibility to remind you of the appointments as this is a courtesy service we aim to render. In addition, we may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
4. The practice uses an off-site billing specialist that may have access to PHI but has agreed to abide by the confidentiality rules of HIPAA.
5. You understand and agree to inspect the office and review of documents, which may include PHI by government agencies or insurance payers in normal performance of their duties.
6. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or your clinician.
7. Your confidential information will not be used for the purposes of marketing or advertising products, goods, or services.
8. We agree to provide patients with access to their records in accordance with state and federal laws.
9. We may change, add, delete, or modify any of these provisions to serve better the needs of both the practice and the patient.
10. You have the right to request restrictions in the use of your PHI and request change in certain policies used within the office concerning your PHI. However, we are not obliged to alter internal policies to conform to your request.
11. Surveillance cameras are present on the property for safety reasons and are being used to maintain the security and safety of staff and patients. Video footage from security cameras will not be used for evaluation purposes.
12. Both parties are prohibited from any type of recording (either voice or video) during sessions.

This form was completed to the best of my knowledge and ability. It will remain my responsibility to update Miracle Counseling and Life Coaching LLC of any future changes.

Patient’s Name

Signature

Date

Relationship to Patient

Signature

Date