Confidentiality Practice Policy and Agreement

Privacy is important for patients seeking treatment and Wellcore Psychiatry of Maryland, LLC strongly protects this right. However, there are exceptions to confidentiality. Information will be shared without confidentiality release in cases where a client is a danger to self or others (Please see the HIPAA notice for more detail explanation and exceptions). Other areas of confidentiality include insurance. Wellcore Psychiatry does work with some insurance groups. If you choose to use accepted insurance plan or you may request reimbursement from your insurance, your medical information will be shared with your insurance company. At a minimum, insurance companies require the type of service provided and diagnosis codes. Lastly, if outstanding balances remain and not addressed adequately, treatment information may be released for collection agency purposes.

nondiscrimination

Wellcore Psychiatry of Maryland, LLC appreciates the mixture of human beings. Equal care will be provided to all patients, regardless of age, race, ethnicity, religion, ability, marital status, sexual orientation, gender identity or gender expression.

MARYLAND NOTICE FORM

Notice of Psychiatric Nurse Practitioner's Policies and Practices to Protect the Privacy of the Patient's Health Information: THIS NOTICE DESCRIBES HOW PSYCHIATRIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

"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 psychiatric practitioner.

- 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 activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "Use" applies only to activities within my office or practice group, 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.

• "Authorization" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or 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 Psychiatry Notes. "Psychiatry 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 Psychiatry Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

Maryland Notice

III. Uses and Disclosures without Authorization

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

Child Abuse – If I have reason to believe that a child has been subjected to abuse or neglect, I must report this belief to the appropriate authorities.

Adult and Domestic Abuse – I may disclose protected health information regarding you if I reasonably believe that you are a victim of abuse, neglect, self-neglect or exploitation.

Health Oversight Activities – If I receive a subpoena from the Maryland Board of Nursing because they are investigating my practice, I must disclose any PHI requested by the Board.

Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated or 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 communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

IV. Patient's Rights and Psychiatric Nurse Practitioners Duties

Patient's Rights:

Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. 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. On 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. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You have the right to inspect or obtain a copy (or both) of Psychiatry Notes unless I believe the disclosure of the record will be injurious to your health. On your request, I will discuss with you the details of the request and denial process for both PHI and Psychiatry Notes.

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. 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.

Psychiatric Nurse Practitioner 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 inform current patients of revision by telephone or post.

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 me by telephone or post.

You may also send a written complaint to:

Secretary of the U.S. Department of Health and Human Services Office of the Secretary,
Hubert Humphrey Bldg
2000 Independence Avenue, S.W.
Washington, DC 20201 (tel) 202 690-7000

VI. Effective Date, Restrictions, and Changes to Privacy Policy: This notice will go into effect on July, 1, 2020.

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. I will provide you with a revised notice by telephone or post.

Please sign next page and return signature page to Clinician or Office Manager.

Patient's Acknowledgement of Receipt of Notice of Privacy Practices Maryland HIPAA

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

I have been provided a copy of the Notice of Privacy Practices for WELLCORE PSYCHIATRY OF MARYLAND, LLC.

My clinician and I have discussed these policies, and I understand that I may ask questions about them at any time in the future.

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

I am aware that I will be directly billed a $75.00 No-Show fee.

I am aware I will be directly billed a $75.00 short notice cancellation/reschedule fee if I don't cancel within 24hrs with the exception of a genuine emergency or inclement weather.

Patient Signature:_
Date:_____

Patient's Name Printed: _____

For Patient's under 18:

Parent or Guardian Signature: _____
Date:_____

Parent or Guardian Name Printed_____

Witness Signature:_____Date:
_____

Witness's Name Printed: _____