

NATHANIEL SMITH, LICENSED PROFESSIONAL COUNSELOR  
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AND SIGN THE ACKNOWLEDGEMENT OF RECEIPT.

Protecting Your Personal and Health Information:

Nathaniel Smith, LPC (“Counselor”) is committed to protecting the privacy of client personal and health information. Applicable Federal and State laws require that I maintain the privacy of clients’ protected health information (“PHI”) and that I provide you with this Notice to explain my privacy practices, legal duties, and your rights concerning your privacy.

In this Notice, your personal or protected health information (PHI) is referred to as health information” and includes information regarding your health care and treatment with identifiable factors such as your name, age, address, income or other financial information. I will follow the privacy practices described in this Notice while it is in effect. This Notice takes effect December 1, 2005 and will remain in effect until replaced.

A. How I Protect Your Health Information:

I protect your health information by:

1. Treating all of your health information that I collect as confidential. (For exceptions to confidentiality, please see Sections B-D below).
2. Restricting access to your health information only to those staff members who need to know your health information in order to facilitate my services to you.
3. Only disclosing the minimum of your health information necessary for an outside service company to perform its function on my behalf; such companies have by contract agreed to protect and maintain the confidentiality of your health information.
4. Maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your health information.

B. 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, as long as you have given your *consent to receive evaluation or treatment services from me*. To help clarify these terms, here are some definitions:

1. “Treatment, Payment, and Health Care Operations” Treatment is when a clinician provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when I consult with your treating physician or psychiatrist to coordinate your care. Treatment also includes activities conducted to provide for direct or indirect supervision of Professional Counseling Interns providing treatment services.

2. "Payment" is when you provide reimbursement for the services you receive from me.
3. "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, case management and care coordination, conducting training and educational programs or accreditation activities.
4. "Use" applies only to activities within my practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
5. "Disclosure" applies to activities outside of the Clinic, such as releasing, transferring, or providing access to information about you to other parties.

C. Uses and Disclosures Requiring Authorization:

I may use or disclose PHI for purposes outside treatment, payment, or healthcare operations when your 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 or healthcare operations, I will generally obtain an authorization from you before releasing this information. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that I have relied on that authorization to provide your services. Records pertaining to couples and families seeking joint treatment will not be released without authorization from all adults participating in the sessions.

D. Uses and Disclosures with Neither Consent nor Authorization:

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

1. Abuse – If I have reason to believe that a minor child, elderly person or disabled person has been abused, abandoned, or neglected, I must report this concern or observations related to these conditions or circumstances to the appropriate authorities.
2. *Health Oversight Activities* – If the Texas State Board of Examiners for Professional Counselors or other licensing or accrediting body is investigating a clinician that you have filed a formal complaint against, I may be required to disclose protected health information regarding your case.
3. *Judicial and Administrative Proceedings as Required* If you are involved in a court proceeding and a court subpoenas information about the professional services provided you and/or the records thereof, I may be compelled to provide the information. Although courts have recognized a therapist-client privilege, there may be circumstances in which a court would order me to disclose personal health or treatment information. I will not release information unless I have written authorization from you or your legally

appointed representative or a valid and binding order from a court of competent jurisdiction. However, the privilege does not apply when you are being evaluated for a third party (e.g. Law enforcement agency or Social Security) or where the evaluation is court ordered.

5. *Serious Threat to Health or Safety* – If you communicate to me or any personnel working for me an explicit threat of imminent serious physical harm or death to identifiable victim(s), and I believe you may act on the threat, we have a legal duty to take the appropriate measures to prevent harm to that person(s) including disclosing information to the police and warning the victim. If I have reason to believe that you present a serious risk of physical harm or death to yourself or others, I may need to disclose information in order to protect you. In either case, I will only disclose what I feel is the minimum amount of information necessary.
6. To notify emergency response personnel about a possible exposure to AIDS or HIV.
7. *Worker's Compensation* – I may disclose protected health information regarding you as authorized by, and to the extent necessary to comply with, laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
8. *National Security*- I may be required to disclose to military authorities the health information of Armed Forces personnel under certain circumstances. I may be required to disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. I may be required to disclose health information to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.
9. *Required by Law*-As otherwise required by federal, state or local law, judicial board or administrative proceedings, or by law enforcement officials with written authority such as a valid and binding court order or warrant.

#### E. Client Rights and Counselor's Duties:

##### 1. Client Rights:

- A. *Right to Request Restrictions* – You have the right to request additional restrictions on certain uses and disclosures of protected health information (PHI). I may not be able to accept your request, but if I do, I will uphold the restriction unless it is an emergency.
- B. *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 being seen by me. On your request, I will communicate with you at another address.)

- C. *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of your records. A reasonable fee may be charged for copying. Access to your records may be limited or denied under certain circumstances, but in most cases you have a right to request a review of that decision. On your request, I will discuss with you the details of the request and denial process.
- D. *Right to Amend* - You have the right to request in writing an amendment of your health information for as long as PHI records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, I will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.
- E. *Right to an Accounting* –You generally have the right to receive an accounting of disclosures of PHI. If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.
- F. *Electronic vs. Paper Copy* – If you received this notice electronically (e.g., accessing a website), you have the right to obtain a paper copy of the notice upon request.

2. Changes to this Notice:

I reserve the right to change privacy practices and terms of this Notice at any time, as permitted by applicable law. I reserve the right to make the changes in privacy practices and the new terms of any Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make such changes, we will update this Notice and post the changes in the waiting room. You may request a copy of the Notice at any time.

3. Questions and Complaints:

For questions regarding this Notice or my privacy practices, please contact Nathaniel Smith directly at 214-205-0237.

If you are concerned that your privacy rights may have been violated, you may contact Nathaniel Smith at 214-205-0237 or you may also make a written complaint to the U.S. Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201 whose address can be provided upon request. If you choose to make a complaint to the U.S. Department of Health and Human Services or to me directly, I will not retaliate in any way.

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**Client Acknowledgement:**

I acknowledge I have received the ***Notice of Privacy Practices*** of Nathaniel Smith, LPC.

\_\_\_\_\_  
Patient / Patient Representative Name

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
Signature of provider representative

\_\_\_\_\_  
Title of provider representative