Be You Counseling Services, LLC
640 George Washington Highway, Building B, Suite 103 #19
Lincoln, RI 02865
401-580-8452

NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

II. I HAVE LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION.

This notice explains how I use and disclose your protected health information ("PHI" for short). I am required by law to protect privacy of PHI, and to provide you with this notice and follow the privacy practices described in it.

PHI includes information that I create or receive about you past, present, or future physical or mental health or condition, the provision of health care to you, or the payment for health care provided to you.

I may change the terms of this notice and my privacy practices at any time. Any change I make will apply to the PHI that I already have as well as to any new PHI I create or receive. When I change my practices, I will promptly change this notice and post it in the main reception area of my office.

III. HOW I MAY USE AND DISCLOSE YOUR PHI.

I use and disclose PHI for many different reasons. Below I describe the different reasons and give you some examples.

A. **Use and disclose of PHI for treatment, payment or health care operations.** I may use and disclose PHI for the following reasons:

1. **For treatment.** I may use and disclose PHI in order to provide therapy, counseling, treatment, and other services to you. For example, I may disclose PHI about you to consult with other professionals about your care. I will obtain your consent before disclosing PHI for treatment purposes if state law requires me to do so.

2. **For payment.** I may use and disclose PHI in order to bill and collect payment for the treatment and services provided to you. For example, I may disclose PHI to your health plan to get paid for the health care services provided to you. I my also disclose PHI to billing companies and companies that process my health care insurance claims. I will obtain your consent before disclosing your PHI for payment purposes if state law requires me to do so.

3. **For health care operations.** I may use and disclose PHI in order to operate this practice. For example, I may use PHI in order to evaluate the quality of services that you receive. I may also disclose PHI to my accountants, attorneys, and others in order to make sure I am complying with the laws that affect me. I will obtain your consent before disclosing your PHI for the purposes of my health care operations if state law requires me to do so.

B. **Other uses of PHI.** I my also use and disclose your PHI for the following reasons:

1. **Reports required by law.** I may disclose PHI when legally required to do so. For example, I may use PHI to make mandatory reports to various government agencies about suspected abuse, neglect, mistreatment, or exploitation of vulnerable people such as children and elderly.

2. **Health oversight.** I may disclose your PHI to certain government agencies authorized by law to license, audit, inspect or investigate health and mental health care providers and the health care system.

3. **To avoid harm.** Consistent with state law, I may disclose PHI to the police or other appointed person, in order to avoid a serious threat to health or safety of a client, another person, or the public.

4. **Appointment reminders, treatment alternatives, and health related benefits or services.** I may use PHI to give you appointment reminders; or give you information about treatment choices or other health or mental health care services or benefits I offer.

5. **Legal proceedings.** I may disclose PHI pursuant to a valid court order, search warrant, and under certain circumstances, in response to a subpoena or other discovery request.

6. **As required by law.** I will disclose PHI when required to do so by federal or state law.

C. **When my use or disclosure of PHI requires your prior authorization.** I must ask for your written authorization for any use or disclosure of PHI not described in sections III-A or III-B above. If you authorize me to use or disclose your PHI, you can late withdraw the authorization and stop any future use or disclosure of you PHI based on it. You can withdraw an authorization by written request to: Naydeen Kafalas, LMHC, 2138 Mendon Road, Suite 104, Cumberland, RI 02864.

NOTICE OF PRIVACY PRACTICES
Receipt and Acknowledgement of Notice

Client Name: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy Naydeen Kafalas, LMHC Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Naydeen Kafalas, LMHC.

_____ _____

Signature of Client **Date**

_____ _____

Signature of Parent, Guardian or Personal Representative **Date**

***Please specify your legal authority to act for this individual (i.e. power of attorney, healthcare surrogate, etc.)**

☐ **Client Refuses to Acknowledge Receipt:**

_____ _____

Signature of Witness **Date**