SERENITY
COUNSELING
SERVICES

HIPAA Compliance Notification

All health professionals and office staff continuously undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." I strive to achieve the highest standards of ethics and integrity in performing services for our patients. It is my policy to properly determine appropriate uses of Personal Health Information (PHI) in accordance with HIPAA. I am required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. I want to ensure my clients that my practice will not knowingly contribute in any way to the growing problem of improper disclosure of PHI. As part of this plan, I have implanted a compliance procedures that will help prevent any inappropriate use of PHI. By signing below, you are acknowledging that you have read and been made aware of this notice of my privacy practices.

X

_____ _____

Name of Patient (Please Print) Date

X_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

Patient's Rights & Responsibilities

If you are or have been a patient of mental health services, you have the right to

- Access services that are appropriate to your disability, culture, language, gender, and age
- Be treated with respect and with due consideration for your dignity and privacy
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand
- Participate in decisions regarding your health care, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of your medical records
- An individualized treatment plan to ensure quality care and coordination of care.
- Access medical care for treatment of physical ailments.

□ I acknowledge the above information and my patient rights and responsibilities.

X

_____ _____

Name of Patient (Please Print) Date

X_____ _____

Signature of Patient (or Parent/Legal Guardian) Date