Ethos Leaders LLC Counseling Services
Bryant Kusy, MA, LCPC
1243 E Iron Eagle Dr. Suite 130D Eagle, ID 83616
Phone: (208) 391-7050
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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A federal law commonly known as HIPAA (Health Insurance Portability and Accountability Act) requires that I take additional steps to keep you informed about how I may use information that is gathered to provide health care services to you. As part of this process, I am required to provide you with this Notice of Privacy Practices and to request that you sign the written acknowledgement that you received a copy of the Notice.

If you have any questions about this notice, please contact me at (208) 391-7050.

MY PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.

I only release information in accordance with state and federal laws and the ethics of the social work profession.

I. **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION **Use and disclosure of protected health information for the purposes of providing services **-** Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow me to use and disclose your health information for these purposes.

A. **Permissible Uses and Disclosures without Your Written Authorization** - I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. **Treatment**: I may use and disclose PHI to provide, manage or coordinate care; to consult with other health care providers involved in your treatment, and with referral sources.

2. **Payment**: I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example, I may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

3. **Health Care Operations:** I may use and disclose PHI in connection with the health care operations of my practice, including review of treatment procedures, quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. **Required or Permitted by Law:** I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law .

B. **Uses and Disclosures Requiring Your Written Authorization**

1. **Psychotherapy Notes**: Notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

2. **Marketing Communications**: I will not use your health information for marketing communications without your written authorization.

3. **Other Uses and Disclosures**: Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. **Right to Inspect and Copy**. You may request access to your medical record and billing records maintained by me to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you. However, I will be happy to meet with you directly to discuss the client’s progress or provide a summary of the clinical notes.

B. **Right to Request Confidential Communications.** You have the right to ask me to communicate with you in a confidential way, such as by phoning you at work rather than at home or by mailing information to a different address. I will accommodate these requests if they are reasonable. If you want to ask for confidential communication, your request must be in writing.

C. **Right to Request Restrictions**. You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to me as indicated below. I am not required to agree to any such restriction you may request.

D. **Right to Accounting of Disclosures**. Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after January 1, 2020. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. **Right to Request Amendment**. You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

F. **Right to Obtain Notice**. You have the right to obtain a paper copy of this Notice by submitting a request to me at any time.

G. **Questions and Complaints**. If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact me in writing at 1243 E. Iron Eagle Dr Ste 130D, Eagle, ID 83616

You may also file written complaints to the Secretary of Health and Human Services. **I will not retaliate against you for filing a complaint.**

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. **Effective Date**. This Notice is effective as of January 1, 2020.

B. **Changes to this Notice**. I may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in the waiting area of my office. You may also obtain any revised notice by contacting me.

This Form is educational only, does not constitute legal advice, and covers only federal, not state law.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

_____ _____

Signature of Client(s) Date

_____ _____

Signature of Client(s) Date

_____ _____

Signature of Bryant Kusy, LCPC Date

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT for ONLINE DOCUMENTS. IF PRINTED PLEASE SIGN ABOVE.