Privacy Practices

This notice went into effect on January 01, 2024

HIPAA NOTICE: Your Information. Your rights. Our responsibilities

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

Sol Healing PLLC has been and will always be totally committed to maintaining client confidentiality. Erin Burns is our Privacy Officer and can be contacted at 630-216-9366 or info@solhealingcounseling.com. We are required by law to maintain the privacy and security of your protected health information. We will follow the duties and privacy practices in this notice. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION FOR THE PURPOSES OF PROVIDING SERVICES AND YOUR RIGHTS. Providing treatment services, collecting payment, and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT: We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants, other professionals who are treating you and potential referral sources.

PAYMENT: Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS: We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance, and licensing activities.

OTHER USES OR DISCLOSURES OF YOUR INFORMATION WHICH DOES NOT REQUIRE YOUR CONSENT: There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Reporting suspected abuse, neglect, or domestic violence. Preventing or reducing a serious threat to anyone's health or safety. As stated in the informed consent section, Confidentiality and Emergency Situations, for other uses or restrictions of your information based on State or Federal law. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

RIGHT TO REQUEST HOW WE CONTACT YOU: It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

RIGHT TO INSPECT AND COPY YOUR MEDICAL AND BILLING RECORDS: You have the right to inspect and obtain a copy of your information contained in your medical records. To request access to your billing or health information, contact the Privacy Officer. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

RIGHT TO ADD INFORMATION OR AMEND YOUR MEDICAL RECORDS: If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request within 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the Privacy Officer. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You may request an accounting of disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosures made for a specific time period no longer than six years and after 01/01/2023, please submit your request in writing to the privacy officer. We will notify you of the cost involved in preparing this list.

RIGHT TO RELEASE OR REQUEST RESTRICTIONS ON USES AND DISCLOSURES OF YOUR HEALTH INFORMATION: You may revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization. You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our Privacy Officer. However, we are not required to agree to such a request.

RIGHT TO COMPLAIN: If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services 200 Independence Ave. S.W., Washington, D.C. 20201 or 877-696-6775. An individual will not be retaliated against for filing such a complaint.

RIGHT TO RECEIVE A COPY OF THIS AND ANY CHANGES IN POLICY: You have the right to receive a copy of this document and any future policy changes secondary to changes in state and federal laws. This can be obtained from the Privacy Officer.

Clinical records, psychotherapy notes and other disclosures require a separate signed release of information. You have a right to or will receive notification of a breach of any unsecured personal health information. You have a right to restrict any disclosure of personal health information where you have paid for services out-of-pocket and in full.

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.

* BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Name:_____

Signature of Client/Guardian (if minor):

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Date_____