
NOTICE OF PRIVACY PRACTICES

Our commitment to your privacy.

Our practice is dedicated to maintaining the privacy of your personal information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This notice is a shorter version of the full, legally required Notice of Privacy Practices (NPP), posted in our waiting room that you can refer to for more information. However, we cannot cover all possible situations, so please talk to our Privacy Officer (see the end of this notice) about any questions or problems.

We will use the information about your health that we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities that are called, in the law, health care operations. After you have read this NPP, we will ask you to sign a Consent Form to let us use and share your information. **If you do not consent and sign this form, we cannot treat you.**

If we, or you, want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you, and ask you to sign an Authorization Form to allow this.

Of course, we will keep your health information private, but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety, or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement or official requires us to do so.
4. For Workers Compensation and similar benefit programs.

There are other situations similar to these that don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information:

1. You can ask us to communicate with you about your health and related issues in a particular way, or at a certain place, that is more private for you. For example you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell people involved in your care, or the payment for your care, such as family members and friends. While we do not have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can even get a copy of these records, but we may charge you. Contact our Privacy Officer to arrange how to see your records. See below.

4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing, and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP, we will post the new version in our waiting area, and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide you in any way.

If you have any questions regarding this notice, or our health information privacy policies, please contact our Privacy Officer who is Gregory C. Keck, Ph.D., and can be reached by phone at 440-230-1960, voicemail #2.

The effective date of this notice is April 14, 2003.

Gregory Keck, PhD
ABC of Ohio
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440-230-1960
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attachment and bonding center of ohio

gregory c. keck phd

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____ and the Attachment and Bonding Center of Ohio. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his or her name here:

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you, and to provide any treatment to you. We may also share this information with others who provide treatment to you, or need it to arrange payment for your treatment, or for other business or government functions.

By signing this form, you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read the NPP before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change the NPP, you can obtain a copy from our Privacy Officer.

If you are concerned about some of your information you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer, telling us you no longer consent), and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

Signature of client or parent/legal guardian if minor

Date

Printed name of client or parent/legal guardian if minor

Relationship to client

Signature of authorized representative of this practice

DATE OF NPP _____

_____ Policy given to client/parent/legal guardian

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