

## LOURDES ORTIZ, LCSW-R

### Privacy Practice and Confidentiality

I recognize that personal problems are sometimes very difficult to talk about. That is why I value confidentiality, it is extremely important to me. I will take every precaution to protect your privacy.

I conduct business in accordance with the guidelines established by the Health Insurance Portability and Accountability Act (HIPPA). This notice describes how private health information (medical information) about you may be used and disclosed and how you can get access to this information. Please review it carefully and feel free to ask questions.

1. I maintain documentation of your contact with me. This documentation includes a "minimum necessary" standard relevant to your protected health information.
2. I provide a safe and secure place to address your personal problem(s). I will help to assess the problem(s) and develop the most appropriate plan of action with you. The plan may include counseling and/or a referral to an appropriate person or program to help resolve your problem. By acknowledging receipt of this document you are providing consent for me to engage in these activities for the purpose of coordinating your care.
3. If you have mental health insurance coverage and choose to use it towards reimbursement for the cost of therapy, please note that your insurance company has the right to, and often will, ask me to divulge confidential information about you in order to evaluate the appropriateness of treatment. The information requested may include, but is not limited to, your diagnosis, the psychosocial stressors in your life, your mental health status, your capacity to work, relate, and maintain yourself, et cetera. Your insurance coverage may be available only as deemed "Medically Necessary" by the case manager at the insurance company or managed care organization handling your mental health benefits. It is therefore, incumbent upon you to know how your health plan coverage is processed, who has access to this information, and what kind of data will be required in order to make a determination of your eligibility for benefits.
4. Your authorization is subject to revocation upon request in writing at any time. I will provide an account of disclosures relevant to this authorization upon request.
5. You may initiate restrictions on certain uses and disclosures of your protected health information; I will do everything possible to reach a reasonable consensus with you in regard to these restrictions. However, I may deny service if it deems such restrictions would significantly preclude my ability to provide you with professional services.
6. There are four limitations to confidentiality, which are beyond my control. They are as follows:
  - If I learn of any alleged child abuse or neglect of the elderly, I am required by law, as a mental health professional, to report this to the State Child Abuse Registry or State Adult Protective Services. This information will not be shared with anyone else.
  - If in my judgment a client is dangerous to himself/herself or others, I may need to break confidentiality in order to assure a client's safety or the safety of others.
  - If a client reveals to me information relating to the contemplation of a criminal act, I may need to break confidentiality to prevent any criminal act.
  - If I am required to present records to comply with a court order.
7. I will abide by the terms of this notice. I reserve the right to make changes to privacy practices and will provide you with a revised notice relevant to your protected health information as long as you are an active client.

Print Name: \_\_\_\_\_ Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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