



37 Calumet Parkway, Bldg. J., Suite 101 & 102;  
Newnan, Georgia 30263  
Office: 770-683-6946 Fax: (770) 683-6949  
[Http://www.wilwoakgeorgia.com](http://www.wilwoakgeorgia.com)

## GEORGIA HIPAA NOTICE

**Notice of Policies and Practices To Protect the Privacy of Your Health Information in Accordance with The Health Insurance Portability and Accountability Act (HIPAA) and Georgia State Laws.**

**THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION UNDER THE NEW HIPAA LAWS. PLEASE REVIEW IT CAREFULLY.**

### **I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

I may use or disclose your protected health information (PHI), for treatment, payment, and healthcare operations purposes with your consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Healthcare Operations” is when I provide, coordinate or manage your healthcare and other services related to your healthcare. An example of treatment would be when I consult with another healthcare provider, such as your family physician or psychologist.
- “Payment” is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- “Healthcare Operations” are activities that relate to the performance and operation of my practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

### **II. Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, or healthcare operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or healthcare operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. “Psychotherapy Notes” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

### **III. Uses and Disclosures with Neither Consent nor Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:



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Serious Threat to Health or Safety – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

- Child Abuse – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.
- Adult and Domestic Abuse – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.
- Health Oversight – If I am the subject of an inquiry by the Georgia Board of Psychological Examiners or the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists, I may be required to disclose protected health information regarding you in proceedings before the Board.
- Judicial or Administrative Proceedings–If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Worker’s Compensation– I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

#### **IV. Patient’s Rights and Psychologist’s and Counselor’s Duties**

- Right to Request Restrictions–You have the right to request restrictions on certain uses and Disclosures of protected health information. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations–You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- Right to Inspect and Copy–You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. An appointment will be scheduled to review these records in my presence so that any issues can be discussed. Normal hourly and/or copying charges will apply. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend–You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. Upon your request, I will discuss with you the details of the amendment process.
- Right to an Accounting–You generally have the right to receive an accounting of disclosures of PHI. Upon your request, I will discuss with you the details of the accounting process.
- Right to a Paper Copy–You have the right to obtain a paper copy of the notice from me upon request.



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**Psychologist's/Counselor's Duties:**

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you at the mailing address you provided.

**V. Complaints**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact us at (770) 683-6946; via email at [COMPLIANCE@wilwoakgeorgia.com](mailto:COMPLIANCE@wilwoakgeorgia.com) or via U.S. mail at 37 Calumet Parkway, Bldg. J. Suite 101 & 102, Newnan, GA. 30263. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

**V. Restrictions**

I will limit the uses or disclosures that I will make as follows:

I will not release the contents of "Psychotherapy Notes" under any circumstance with the following exceptions:

- If you file a lawsuit or ethics complaint against me, I may release "Psychotherapy Notes" for use in my defense.
- When the following "Uses and Disclosures when Neither Consent nor Authorization" apply:
  - Child Abuse
  - Adult and Domestic Abuse
  - Health Oversight
  - Judicial or Administrative Proceedings
  - Serious Threat to Health or Safety

**Client Information and Consent for Services and the Georgia HIPAA Notice Signature Page**

I have read, understand, and agree to abide by the terms and conditions set forth in the Client Information and Consent for Services, and do hereby consent to participation in the treatment as described in the consent agreement. I also understand that my participation is entirely voluntary and that I may withdraw my consent and terminate treatment at any time. I have been provided with the Georgia HIPAA Notice and I understand. HIPAA is a federal law that provides privacy protections and assures patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a complete printed copy of the Georgia HIPAA Notice for use and disclosure of PHI for treatment, payment and healthcare operations. The Georgia HIPAA Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. We can discuss any questions that you may have about the procedures outlined in the Georgia HIPAA Notice.

\_\_\_\_\_  
Patient (or Guardian) Signature

\_\_\_\_\_  
Date



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If you intend on using your health insurance to help pay for treatment, please read and sign the following: I hereby authorize Willow Oak Community Behavioral Health Center, LLC to furnish my insurance company with all the information they request. I also instruct my insurance company to pay my claim directly to Willow Oak Community Behavioral Health Center, LLC where applicable. I understand that if my insurance requires authorization and I choose to receive services before written authorization has been received by Willow Oak Community Behavioral Health Center, LLC, that I will accept financial responsibility for all charges. I understand that authorization is not a

Guarantee of payment. I also understand that even if services are authorized, that if I am not eligible on the date of service, or if it is later determined that my policy does not cover the item(s) I am receiving, I may be responsible for payment in full. I further understand that my insurance company may deduct a co-pay, a percentage, and/or a deductible from their payment to Willow Oak Community Behavioral Health Center, LLC I agree to pay promptly for these amounts.

\_\_\_\_\_  
Insured's Signature or Legal Guardian

\_\_\_\_\_  
Date