Amy Beckman, LCSW

McLean Professional Park
1499 Chain Bridge Rd., Suite 200
McLean, VA 22101
703-356-3239

NOTICE OF PRIVACY PRACTICES (NPP)

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.

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am required by law to keep your information private. These laws are complicated, but I must give you this important information. This form is a shorter version of the full legally required NPP. Please feel free to discuss with me any questions or problems.

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

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

Though I will keep your health information private there are times when the law requires mental health professions to disclose information. 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. I will only share information with a person or organization which is able to help prevent or reduce the threat.

2. Suspected child abuse or neglect must be reported to the proper authorities.

3. If you are a party to a lawsuit or other legal proceedings and I am served with a subpoena I may have to release some of your health information. I will try and make certain that you have been made aware of the subpoena, so that you may take appropriate action to protect your privacy.

4. If a law enforcement official requires me to do so.

5. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

Your Rights Regarding Your Health Information

- You can ask me to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask me to call you at home, and not at work to schedule or cancel an appointment. I will try my best to do as you ask.

- You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends. While I don't have to agree to your request, if I do agree, I will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

- You have the right to look at the health information we have about you such as your medical and billing records. With your request in writing you can even get a copy of these records but there may be a charge.

- If you believe the information in your records is incorrect or missing important information, you can ask me to make some kinds of changes to your health information. You have to make this request in writing including the reasons you want to make the changes.

- You have the right to a copy of this notice. If I change this NPP I will post a new version in the waiting area and you can always request a new copy for self.

- You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint 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 I provide to you in any way.

If you have any questions regarding this notice or my health information privacy policies, please speak with me about your concerns.

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

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I _____, acknowledge that I received a copy of the Notice of Privacy Practices for the clinical practice of Amy Beckman, LCSW. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Ms. Beckman.

_____ _____

Signature Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client:_____

For Office Use Only

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign.

_____ Communications barriers prohibited obtaining the acknowledgment.

_____ An emergency situation prevented us from obtaining acknowledgment.

_____ Other (please specify) _____

This form will be retained in your record.

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CONSENT TO USE AND DISCLOSE YOUR HEATH INFORMATION

This form is an agreement between you, _____and me. When I 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 _____.

Through our work together I will be collecting what the law calls Protected Healthcare Information (PHI) about you. I need to use this information to decide what treatment is best and then 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 explains in more detail your rights and how we can use and share information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in my Notice of Privacy Practices (NPP) I cannot treat you. If any changes are made to the NPP a new copy will be made available.

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 me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I will do as you ask.

After you have signed this consent, you have the right to revoke it by writing a letter to me stating that you no longer consent. I will comply with your wishes about using or sharing information from that time on but may have already used or shared some of your information and cannot change that.

_____ _____
Signature of client or representative Date

_____ _____
Printed Name (If representative, relationship to client)

_____
Description of personal representative's authority

_____ (Clinicians Signature)

Date of NPP _____ _____Copy given to the client/parent or representative.

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AUTHORIZATION FORM

1. I am completing this form to allow the use and sharing of protected health information about
Printed name:_____ Date of Birth_____

2. I authorize this person or organization:

_____

_____

3. To use or disclose the following information:

_____ Inpatient or outpatient treatment records for physical and or psychological, psychiatric, or emotional illness.

_____ Admission and discharge summaries.

_____ Psychological or psychiatric evaluation(s) reports, assessments, treatment notes, summaries or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.

_____ Reports of consultants.

_____ Academic and educational records, including achievement and other tests' results, reports of teachers' observations and all other school or special education documents.

_____ Other:
_____

Dates of care included: From:_____ To:_____
From: _____ To:_____

4. To this person or organization: _____

5. The information will be used/disclosed for the following purposes:

_____

6. I understand and agree that this Authorization will be valid and in effect until this

Authorization expires on _____. I understand that after that date no more of this information can be used or released to the person or organization unless a new one is signed.

7. I understand that I can revoke or cancel this authorization at any time by putting my request in writing. If I do this, it will prevent any disclosures after the date it is received but can not change the fact that some information may have been sent or shared before that date.

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment, nor will it affect my eligibility for benefits.

9. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copy or other services.

10. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal regulations, the information described above may be re-disclosed and no longer protected by those regulations.

11. I understand that the professional or facility listed in number 2, above, will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it.

12. I affirm that everything in this form that was not clear to me has been explained and I believe now understand all of it.

_____ _____
Signature of client or representative Date

_____ _____
Printed Name (If representative, relationship to client)

_____
Description of personal representative's authority

_____ I acknowledge that I received a copy of this completed form.

I, Amy Beckman, LCSW, have discussed the issues above with the client and/or his or her personal representative. My observations of his or her behavior and responses give me no reason to believe that the person is fully competent to give informed and willing consent.

Signature Amy Beckman Date