Taalya Areli, LMFT, Ph.D.
License No. LMFT 105961
41690 Enterprise Circle N.
Temecula CA 92590
951-331-3707

Dove Spirit
Love, Tranquility, Hope and Healing

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review this notice carefully. Your health record contains personal information about you and your health. This information about you that may identify you and things related to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI") as defined by the Health Insurance and Portability Act. This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and the AAMFT Code of Ethics and guidelines. It also describes your rights regarding how you may gain access to and control your PHI. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, explains HIPAA and its application to your PHI in greater detail.

I am required by law to maintain the privacy of your PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices.

The law also requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document.

I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website (if website is available), sending a copy to you in the mail/secure email upon request or providing one to you at your next appointment.

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HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization. I may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Payment. In the event that I accept insurance in the future, I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Required by Law. Under the law, I must disclose your PHI to you upon your request.

WITHOUT AUTHORIZATION

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. However, there are situations in which uses and disclosures are permitted by HIPAA *without* an authorization. Applicable law and ethical standards permit me to disclose information about you *without* your authorization only in a limited number of situations.

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There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

Child Abuse. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with California Child Protective Services. Once such a report is filed, I may be required to provide additional information.

Vulnerable Adult/Elder abuse. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the appropriate agencies. Once such a report is filed, I may be required to provide additional information.

Physical harm to the patient, to other individuals, or to society. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

Judicial and Administrative Proceedings. I may disclose your PHI pursuant to a subpoena, court order, administrative order or similar process (such as responding to a court or administrative order), If possible my preference is to obtain an Authorization from you before doing so.

Business Associates. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Deceased Patients. I may need to disclose PHI regarding deceased patients to coroners, medical examiners, or funeral directors and to organizations relating to organ, eye, or tissue donations or transplants when such individuals are performing duties authorized by law.

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Medical Emergencies. I may use or disclose your protected health information in a medical emergency to medical personnel only to prevent serious harm. I will try to inform you of this notice as soon as reasonably practical after the resolution of the emergency.

Health Oversight. If required, I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program, and peer review organizations performing utilization and quality control.

Law Enforcement. I may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena, court order, administrative order or similar document, for identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them. I may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm. I may disclose your PHI to worker's compensation and disability programs, or to correctional facilities if you are an inmate.

Lawsuit against me. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

Public Health. If required, I may use or disclose your PHI to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. I may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed

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to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Appointment Reminders. I am permitted to contact you to provide appointment reminders or to inquire about missed sessions. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Research. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received

If disclosure is otherwise specifically required by law. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked, in writing, to stop any future uses and disclosures.

Uses and disclosures that require you to have the right to object.

Disclosures to family, friends, and others. I may use or disclose your PHI to a family member or friend or other person who you indicate is involved in your care or responsible for the payment for your health care unless you object. Retroactive consent may be obtained in emergency situations.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to: Taalya Areli, LMFT, Ph.D. to 28360 Old Town Front St. #389, Temecula CA 92593.

Right to Treatment. You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.

Right to Confidentiality. You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.

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Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect or obtain a copy of your PHI that is maintained in a "designated record set". Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

Right to Amend. If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.

Right to an Accounting of Disclosures. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the time requested by you. I will provide the list for free, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

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The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

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.

Breach Notification. If there is a breach of unsecured protected health information concerning you, I am be required to notify you of this breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice. You have the right to a copy of this notice. If you received the paperwork electronically, you have a copy in your email or secure portal. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.

Right to Choose. You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.

Right to Choose Someone to Act for You. If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.

Right to Terminate. You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.

Right to Release Information with Written Consent. With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

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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 me, the State of California Department of Health, or the Secretary of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint about my privacy practices.

THERAPIST 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 provide you with a revised notice in office during our session.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

Provider Signature

_____ _____
Taalya T. Areli, LMFT, Ph.D. Date
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