Sherri S. Grady, LPC, LLC
745 Johnnie Dodds Blvd., Suite A
Mount Pleasant, SC 29464
Phone: 843-330-8408 Fax: 843-284-8277
www.sherrigrady.com

Notice of Privacy Practices

As of April 14, 2003, the federal government requires me to disclose my privacy policies to all clients (HIPAA 04/14/03). 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.

I am required by law to protect the privacy of health information that may reveal your identity and to provide you with a copy of this notice, which describes the health information privacy practices of my private practice. A copy of my current notice will always be available in my office. You will also be able to obtain your own copy by calling my office at 843-330-8408 or by asking me for one at the time of your next visit. If you have any questions about this notice or would like further information, please contact me at the office.

What Health Information is Protected

I am committed to protecting the privacy of information I gather about you while providing you with counseling. Some examples of health information are:
-information about your health condition (such as diagnoses)
-information indicating you are a client of my practice

When combined with:
-demographic information (such as you name, address, insurance status)
-unique numbers that might identify you (such as social security and phone numbers)
-other types of information that may identify who you are

Required Permission to Use and Disclose Your Protected Health Information

I will obtain a one-time general written consent to use and disclose your health information in order to treat you, obtain payment for that treatment, and conduct my business operations. This general written consent will be obtained the first time I provide you with treatment or service. This general written consent is a broad permission that does not have to be repeated each time I provide treatment or services to you.

I will generally obtain your written authorization before using your health information or sharing it with others. You may also ask that I transfer your records to another person by completing a written authorization form. If you provide me with written authorization, you may revoke that written authorization at any time, except to the extent that I have already relied upon it or taken action to do what you previously requested. To revoke a written authorization, please write to me at: Sherri S. Grady, LPC/S 745 Johnnie Dodds Boulevard, Suite A Mt. Pleasant, SC 29464.

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How I May Use and Disclose Your Health Information

With your general written consent, I may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run my business operations. In some cases I may also disclose your health information for payment activities and certain business operations of another healthcare provider or payer. Below are further examples of how your information may be used and disclosed for these purposes.

Treatment: I may share your health information with a doctor or other professional outside of this practice to determine how best to diagnose or treat you. I may also share your health information with another doctor or professional to whom you have been referred for further health care.

Payment: If you use third party reimbursement, I am required to provide the insurer with a clinical diagnosis and sometimes a treatment plan or summary. I may use your health information or share it with others so that you can get payment from your health care services. For example, I may share information about you with your health insurance company about your health condition in order to obtain approval for treatment. Finally, I may share your information with other health care providers who have treated you so that they may also have accurate information to seek payment from your health insurance company.

Business Operations: In the course of providing treatment to you or your family member, I may use your health information to contact you with a reminder that you have an appointment for treatment or services at my facility. I may use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

At times, I may use a cellular phone or voice-over-internet phone to contact you or return your calls. Please be aware that I will NOT notify you when I am using such a device so if you feel the information discussed requires a more secure level of confidentiality, please let me know so arrangements can be made to contact you in another way.

I generally discourage e-mails as a mode of communication due to confidentiality concerns. I may reply to e-mails but will make an effort to limit the type of information included due to these confidentiality concerns. Again, e-mail is NOT a confidential mode of communication and is generally not used in this office.

I do routinely use a fax machine in communication with other clinicians and agencies. I will only release information that you have authorized me to release and this information will be sent with a cover sheet that includes a confidentiality statement. This cover sheet cannot insure that the fax is received in the proper place or handled in a confidential manner once it is received. You may pick up and carry documents to agencies/clinicians if you wish and I will also mail documents on special request.

I can do all of these things if you have signed a general written consent form. Once you sign this general written consent form, it will be in effect indefinitely until you revoke your general written consent or specify date for termination. You may revoke your general written consent at any time, except to the extent that I have already relied upon it. To revoke your general written consent, please write to Sherri S. Grady LPC/S 745 Johnnie Dodds Boulevard, Suite A, Mt. Pleasant, SC 29464.

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I may use your health information, and share it with others, in order to treat you in an emergency or to meet important public needs. I will NOT be required to obtain your general written consent before using or disclosing your information for these resources. I will, however, obtain your written authorization for, or provide you with an opportunity to object to the use and disclosure of your health information in these situations when state law specifically requires that I do so.

Emergencies: I may use or disclose your health information in order to treat you, to obtain payment for that treatment, and to conduct our business operations if you need emergency treatment or if I am required by law to treat you but am unable to obtain your general written consent. I will attempt to obtain your general written consent as soon as I am reasonably able to after I have treated you.

Law Enforcement: I may disclose your health information to law enforcement officials for the following reasons:
-to comply with a court order or law that I am required to follow
-to assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing persons
-if you have been the victim of a crime and I determine that:
1. I have been unable to obtain your agreement because of an emergency or incapacity
2. law enforcement officials need this information immediately to carry out their law enforcement duties
3. in my professional judgment, disclosure to these officials is in your best interest
4. if necessary to report a crime that occurred on my property
5. if necessary to report a crime discovered during an offsite medical emergency
6. if I believe that a patient is threatening serious harm to self or others, I am required to take protective action, which may include notifying the police, warning the intended victim, and/or seeking the patient's hospitalization.

Victims of Abuse or Neglect: I may release your health information to a public health authority that is authorized to receive reports of abuse or neglect. For example, I may report your information to government officials if I reasonably believe that you have been a victim of such abuse or neglect. I will make every effort to obtain your permission before releasing this information, but in some cases, I may be required or authorized to act without your permission.

Health Oversight Activities: I may release your health information to government agencies authorized to conduct audits, investigations, and inspections of the practice. The government agencies monitor the operation of health care systems, government benefit programs, and compliance with regulatory programs and civil rights laws.

Lawsuits and Disputes: I may disclose your health information if I am ordered to do so in a court or administrative tribunal that is handling a lawsuit or other dispute. In most judicial proceedings you have the right to prevent me from testifying. However, in child custody proceedings, adoption proceedings, and proceedings in which your emotional condition is an important element, a judge may require my testimony if it is determined that resolution of the issues before the court requires it. If you are involved in litigation, or are anticipating litigation, and you choose to include your mental or emotional state as part of the litigation, I may have to reveal part or all of your treatment or evaluation records.

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If you are called as a witness in criminal proceedings, opposing counsel may have some limited access to your treatment records. My testimony may also be ordered in other cases including legal proceedings relating to psychiatric hospitalization, malpractice and disciplinary proceedings, court-ordered psychological evaluations, and certain legal cases following the death of a patient.

Under current South Carolina law, all participants in group, couples, marital, and family therapy are required to consent to the release of information. One marital partner may not waive privilege for another. In cases of marital therapy, therefore, the record may be released only if both parties waive privileges or release of the record is court ordered.

Notice to Minors: If you are under eighteen years of age, please be aware that your parents have a right to receive general information on the progress of your treatment. Your parents may also request a copy of your record.

Medical Records: I am required to maintain complete treatment records. Clients are entitled to receive a copy of these records, unless I believe the information would be emotionally damaging and, in such cases, the records must be made available to the client's appropriate designee.

Incidental Disclosures: While I will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of my otherwise permissible uses or disclosures of your health information.

Changes to this Notice: In order to stay current with new state and federal laws, I may change this notice and make it effective for medical information I already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a copy of the current notice at any visit or by written request to: Sherri S. Grady LPC/S 745 Johnnie Dodds Boulevard, Suite A, Mt. Pleasant, SC 29464.

Acknowledgement and Consent: By signing below, I acknowledge that I have been provided a copy of this Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the counseling private practice listed at the beginning of this notice, and how I may obtain information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange my medical care, to seek and receive payment for services given to me and for the business operations of this practice.

Signature of Patient or Patient's Personal Representative (describe)

Printed Name of Patient or Patient's Personal Representative

Date

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SPECIFIC UNDERSTANDINGS

In the course of providing treatment to you I may use your health information to contact you with a reminder that you have an appointment for treatment or services at my office. In my interactions with you I may use a cellular or voice-over-internet phone. If you feel the information we are discussing requires a higher level of security, please let me know so arrangements can be made to contact you in another way. Email is not a confidential mode of communication, and though I may reply to emails, I will use every effort to limit the type of information discussed due to these confidentiality concerns.

I also routinely use a fax machine in communication with other agencies. I will only release information you have authorized me to release and will send this with a cover sheet with a confidentiality statement. This does not insure that the fax is received in the proper place or handled in a confidential manner once received. You may pick up and hand-carry documents to agencies if you wish. I will also mail documents on special request.

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. You should note that when your protected health information is disclosed to people or entities that are not required to abide by federal or state medical privacy laws, those people or entities may re-disclose your information to others and use your information without being subject to penalties under those laws.

You have a right to refuse to sign this authorization. Your healthcare, the payment for your healthcare, and your healthcare benefits will not be affected if you do not sign this form.

You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that our practice has already taken action based upon your authorization. To revoke this authorization, please write to me at Sherri S. Grady LPC/S 745 Johnnie Dodds Boulevard, Suite A, Mt. Pleasant, SC 29464.

I have read this form and all of my questions about this form have been answered to my satisfaction. By signing below, I acknowledge that I have read and accept all of the above.

Signature of Patient or Patient's Personal Representative

Print Name of Patient or Patient's Personal Representative

Date

Description of Personal Representative's Authority