Stacey Braffett, LCSW

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 that relates 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"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We 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 we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE 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 the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we 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, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As licensed professionals in this state, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next of kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we 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 (such as thirdparty payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of 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. We 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.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities 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. We 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 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.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to the Privacy Officer: Stacey Braffett LCSW, 25 Central Park West, Suite 1-I, New York, NY 10023.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. 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 or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12 month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a

condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may 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.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy
Officer, Stacey Braffett LCSW, 25 Central Park West, Suite 1-I, New York, NY 10023, and/or by calling (646) 371-6930 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201, or by calling (202) 6190257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient Name: _____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer, Stacey Braffett LCSW, 25 Central Park West, Suite 1-I, New York, NY 10023 and/or by calling (646) 371-6930.

_____

Signature of Patient **Date**

_____

Signature or Parent, Guardian or Personal Representative [*] **Date**

_____

[*] If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient Refuses to Acknowledge Receipt:

_____

Signature of Staff Member **Date**

Stacey Braffett, LCSW

Standard Authorization
Mental Health Treatment

I, _____[Insert Name of Patient], whose Date of Birth is _____, authorize Stacey Braffett to disclose to and/or obtain from:

_____the following information:

Description of Information to be Disclosed
(Patient should initial each item to be disclosed)

_____ Assessment _____ Educational Information
_____ Diagnosis _____ Discharge/Transfer Summary
_____ Psychosocial Evaluation _____ Continuing Care Plan
_____ Psychological Evaluation_____ Progress in Treatment
_____ Psychiatric Evaluation _____ Demographic Information
_____ Treatment Plan or Summary _____ Psychotherapy Notes*
_____ Current Treatment Update (* Cannot be combined with any other disclosure)
_____ Medication Management Information _____ Other_____
_____ Presence/Participation in Treatment _____
Other_____ _____ Nursing/Medical Information

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.
If the purpose is other than marketing, sale of information, research or as specified above, please specify:

_____
_____

Marketing

- If the purpose of this disclosure is for marketing purposes, please check this box and set forth the financial remuneration amount received by Stacey Braffett in exchange for disclosing the information. $_____

Sale of Information

- If the purpose of this disclosure is for the sale, license to use or lease of the information, please check this box.

Research

- If the purpose of this disclosure is for research purposes, please check this box and identify the current

  and future research studies as well as whether each research study is conditioned upon execution of this authorization and individual's ability to opt into each study.

  Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Stacey Braffett LCSW, 25 Central Park West, Suite 1-I, New York, NY 10023. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:_____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____

Signature of Patient Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient refuses to sign authorization

_____

Signature of Staff Witness Date

STACEY BRAFFETT, L.C.S.W

REGISTRATION FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Name: _____

(Last) (First) (Middle Initial)

Name of Parent/Guardian (if under 18):_____

(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Social Security #: _____

Insurance Provider and ID#: _____

Relationship Status: □ Single □ Dating □ Committed/nonMarried □ Married
□ Separated □ Divorce □ Widowed □ Other

Please list any children/ages: _____

Address: _____

(Street and Number) (City) (State) (Zip)

Home Phone: ( ) May I leave a message? □ Yes □ No

Cell/Other Phone: ( ) May I leave a message? □ Yes □ No

Email: _____ May I email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact:
_____

(Name) (Telephone #) (Relation to you)

Have you previously received any type of mental health services (psychotherapy, psychiatric services, psychiatric diagnosis, inpatient, outpatient)?

□ No □ Yes (Is there anything you would like to tell us now?)

_____
_____
_____
_____

Are you currently taking any prescription medication?

□ No □ Yes

Please list
:_____
__

Have you ever been prescribed psychiatric medication?

□ No □ Yes (Is there anything you would like to tell us about what has worked and what hasn't?)

Please list:
_____
_
_____
_____
_____

Any treatment providers to be informed about? (ie:physician, psychiatrist, nutritionist, obgyn, etc)
_____
_____
_____
_____
_____

Other Relevant Info:

(Please use space below to provide any additional info that you would like me to know about you to help facilitate our work together)
_____

_____
_____
_____
_____
_____

Manhattan Psychoanalytic Therapy
Stacey Braffett, LCSW, PLLC
25 Central Park West, Suite 1-l
New York, NY 10023

STATEMENT OF FEE POLICIES

Fee Payment:

It is necessary that patients be responsible for the time reserved for them. You are expected to pay for all regularly scheduled sessions. This includes appointments you do not keep because of circumstances such as a brief illness, business trips, rehearsals, or a school exam (regardless of when you cancel your appointment).

Exceptions to this policy will be granted for pre-planned vacations, serious prolonged illness, death of a family member, holidays, or lack of transportation due to strike or storm. Whenever possible, a rescheduled time or phone session may be an alternative to office sessions as agreed between patient and therapist.

Payment is due at the end of each session by check, cash, or credit card. Unfortunately, we cannot afford to provide services without prompt payment. Therefore, any payment that is 30 days past due will be assessed a 5% service charge. Payments 45 days past due will result in interruption of services until a payment plan can be worked out between Stacey Braffett, LCSW, and the patient.

If you have insurance coverage, you are still responsible for the fee of the session. Co-payments are due at the time of the session each week. You are responsible for providing your insurance and personal information. We will then process and submit the insurance claim and be paid directly by the insurance company.

Patients are responsible for any fees not covered by the insurance company. It is therefore very important that you check with your insurance carrier so that you understand the benefits and limitations of payment. As a courtesy to patients, we submit directly to Blue Cross Blue Shield PPO or EPO plans. If your insurance does not reimburse for services, you are responsible in full for the in-network negotiated fee. You can discuss any concerns with your therapist.

Makeup Appointment:

In certain cases, with advance notice, individual sessions can be rescheduled. Therapists' times are often limited. Therefore, if you miss an appointment, your therapist may or may not be able to give you a makeup appointment. Rescheduled hours are expected to occur within two weeks of the missed

session. Inability to reschedule a makeup session does not waive your fee responsibilities

Cancellation Fee

For in-network insurance patients, there will be a $50 cancellation fee for missed sessions that are not rescheduled. For out of network patients, you are responsible for the full fee for missed appointments.

If you have questions about these policies, please feel free to discuss them with your therapist at any time.

Your signature below indicates that you have read the information in this document and agree to its terms.

Name (please print):

Fee:

Signature:

Date: