Brendan A. Rich, Ph.D.
Clinical Child & Adolescent Psychologist
Licensed Psychologist: Washington, D.C. (PSY1000846)
NPI: 1770981268
Rich Psychological Services, LLC
FEIN: 47-2867111
5225 Wisconsin Avenue NW, Suite 513
Washington, DC 20015
240-672-6617 • info@drbrendanrich.com • www.drbrendanrich.com

Notice of the Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW MEDICAL AND MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

By law, I may *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *written authorization*. I may *use* your PHI without your authorization. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"

– *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another mental health professional.

– *Payment* refers to the process of obtaining reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to facilitate reimbursement for your health care or to determine eligibility or coverage.

– *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care 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 practice, such as sharing, employing, applying,
- utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.
- "*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or health care 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 your therapist may have made about the conversation during a private, group, joint, or family counseling session, which are kept separate from the rest of your record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) 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, or if the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

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

- *Child Abuse* – If I know or have reasonable cause to suspect in our professional capacity that an identified child has been or is in immediate danger of being a mentally or physically abused or neglected, I must immediately report such knowledge or suspicion to the appropriate authority.
- *Adult and Domestic Abuse* – If I believe that an adult is in need of protective services because of abuse or neglect by another person, I must immediately report this belief to the appropriate authorities.
- *Health Oversight Activities* – If the D.C. Boards of Psychology or Social Work is investigating me, I may be required to disclose PHI to the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under D.C. law, and I will not release information without the written authorization of you or your legally appointed representative 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.
- *Serious Threat to Health or Safety* – If I believe disclosure of PHI is necessary to protect you or another individual from a substantial risk of imminent and serious physical injury, I may disclose the PHI to the appropriate individuals.
- *Worker's Compensation* – If I am treating you for Worker's Compensation purposes, I must provide periodic progress reports, treatment records, and bills upon request to you, the D.C. Office of Hearings and Adjudication, your employer, or your insurer, or their representatives.

IV. Patient's Rights and the Mental Health Professional's Duties

Patient's Rights:

- *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, 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. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You may be denied access to Psychotherapy Notes if I believe that a limitation of access is necessary to protect you from a substantial risk of imminent psychological impairment or to protect you or another individual from a substantial risk of imminent and serious physical injury. I shall notify you or your representative if I do not grant complete access. 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. On 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. On 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 us upon request, even if you have agreed to receive the notice electronically.

Mental Health Professional's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of our 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 these policies and procedures, I will provide you with a revised notice of privacy policies and procedures either in person or by mail.

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 DC Board of Psychology. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on June 1, 2014.

VII. Addendum Regarding Issues of Confidentiality Associated with Treating a Minor

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Patient-Therapist Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethical responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

As noted above, I have an ethical and legal duty to break confidentiality when I believe my client or an identified third party is at risk. This means I have a duty to contact appropriate authorities in instances where I believe that my minor client is at risk for harming himself/herself, is at risk for being harmed by someone else, or is at risk for harming another individual.

There are instances in which my need to break confidentiality is less clear. As an example, if your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you. In other situations, where I am concerned about your child's safety but there is not an imminent risk, it is possible that I will work with your child to determine the appropriate course of action, which may include spending therapy sessions to determine if or when I or your child discuss this situation with you. It is important that you respect this process and trust me to discuss with you these issues in a manner that respects the therapist-client relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. It is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. Thus, unless required by ethical or legal standards, I will not share with you what your child has disclosed to me without your child's consent. By signing this agreement, you will be waiving your right of access to your child's treatment records. Of course, I will provide you with general

information about treatment status, and on a weekly basis I will discuss with you your child's general progress and our treatment goals.

It is also important for me to note that in marital situations that involve separation, divorce, visitation, or a custody issue, you agree that neither parent will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your child. In particular, you agree that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such an agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $200 per hour for time spent traveling, preparing reports, testifying, and any other case-related costs.

I, _____, have read, understand, and accept the policies described in this agreement.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ABIDE BY ITS TERMS.

_____ _____
Signature of parent of a minor child Date signed

_____ _____
Signature of parent of a minor child Date signed

_____ _____
Signature of Psychotherapist Date signed