

Client Name _____

Date _____



Art Prennace, LPC, PLLC
Psychotherapist



New Perspectives
Through Compassionate Listening
www.artofcounseling.org

1100 Round Rock Avenue
Round Rock, Texas 78681
Ph: (512) 341-2155
Fax: (512) 369-1799

HIPPA 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 IT CAREFULLY.

As a Licensed Professional Counselor, Art Prennace is committed to maintaining client confidentiality. I will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow me to use and disclose your health information for these purposes.

TREATMENT: I may need to use or disclose health information about you to provide, manage, or coordinate your care or related services. This could include consultants and potential referral sources.

PAYMENT: Information may be disclosed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. I may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS: I may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

OTHER USES OR DISCLOSURES OF YOUR INFORMATION WHICH DOES NOT REQUIRE YOUR CONSENT: There are some instances where I may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse; then by Texas State Law, I **am required** to report this to the Department of Children and Family Services. I **must** disclose if you provide information that informs me that you are in danger of harming yourself or others. I can reveal limited information to remind you of /or to reschedule appointments or treatment alternatives. I may have to share information with law enforcement if a crime is committed on the premises or against the staff or as required by law through a subpoena or court order.

You have read this notice or had it read to you, and you understand how information you disclose in counseling could be used and you understand your rights to privacy.

Your Signature: _____

Date: _____