**NOTICE OF PRIVACY POLICIES AND PRACTICES**

**Premier Mental Wellness**

**2626 Cole Avenue, Suite 300**

**Dallas, Texas 75204**

**Office: 214-661-5786 Fax: 214-661-5782**

**Angel L.A. Adams, MSN, APRN, PMHNP-BC**

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

All items outlined in this policy apply to both paper and electronic formats of medical records and protected health information.

**INTRODUCTION**

Premier Mental Wellness is committed to treating and using protected health information (PHI) about you responsibly. We are permitted to use and disclose health information about you for the treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care you receive. This notice describes our privacy practices. We may change our policies and this notice at any time. You can request a paper copy of this notice, or any revised notice, at any time. This notice is effective October 1, 2019 and applies to all PHI as defined by federal regulations. For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

**HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION**

**We are permitted to use and disclose your health information to those involved in your treatment.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**We are permitted to use and disclose our health information to bill and collect payment for the services we provided to you.**

Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

**We are permitted to use and disclose your health information for the purposes of health care operations, which are the activities that support this practice and ensure that quality care is delivered.** For example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**DISCLOSURES THAT CAN BE MADE WITHOUT YOUR AUTHRIZATION**

**These are situations in which we are permitted to use or disclose your health information without your written authorization or an opportunity to object.**

**Public Health:** We may disclose your health information for public health activities mandated by federal, state or local government for the collection of information about disease, vital statistics or injury by a public health authority.

**Abuse or Neglect:** Because Texas law requires clinicians to report child abuse or neglect, we may disclose health information to a public agency authorized to receive reports of child abuse or neglect.

**Healthcare Oversight:** We may disclose your health information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections.

**Law Enforcement and Legal Proceedings:** We may disclose your medical information if asked by a law enforcement official. We may also release information if we believe the disclosure is necessary to prevent or lessen imminent threat to the health or safety of a person. We may disclose our health information in the course of judicial or administrative proceedings in response to an order of the court or other appropriate legal process.

**Worker’s Compensation:** We may disclose your health information as required by worker’s compensation law.

**Military and National Security:** We may disclose your health information for specialized governmental functions.

**Research and Medical Examiners:** We may release health information to researchers for research purposes. We may release your health information to a coroner or medical examiner to identify a deceased person or a cause of death.

**Business associates:** We may disclose your health information to “business associates” to perform our day-to-day operations. These “associates” require your health information in order to accomplish the tasks that we ask them to provide. Some examples of “business associates” might be a billing service, collection agency, answering services and computer software/hardware provider.

**Appointment reminders:** We may contact you by telephone, e-mail, mail or all to provide appointment reminders.

**Required by Law:** We may release your health information when the disclosure is required by law.

**Other Uses or Disclosures:** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization .If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

**YOUR RIGHTS UNDER FEDERAL LAW**

You have certain rights under the federal privacy standards. These include:

* The right to request restriction on the use and disclosure of your PHI. WE DO NOT HAVE TO AGREE TO THIS RESTRICTION.
* The right to limit disclosure to family members, relative or friends who may or may not be involved in your care. Restrictions must be submitted in writing to the person listed at the end of this document.
* The right to request that we send communications concerning health information by alternative means or to an alternative location. The request must be submitted in writing to the person at the end of this document and we are required to accommodate only reasonable request.
* The right to inspect and copy your PHI that is within the designated record set. Texas law requires that request for copies are made in writing and we require requests for inspection also be made in writing. Texas law requires us to provide copies or a narrative within 15 business days from receipt of your proper request. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based fee.
* The right to amend or submit corrections to your PHI in the designated record set. If we refuse to allow amendment, we will inform you in writing.
* The right to receive an accounting of disclosures that are other than for treatment, payment, health care operations or made via an authorization signed by either you or your representative.
* The right to receive a printed copy of this notice.

**FOR MORE INFORAMTION OR TO REPORT A PROBLEMJ**

If you have complaints, question or would like additional information regarding this notice or the privacy practices of Premier Mental Wellness, please contact:

Privacy Officer Premier Mental Wellness 2626 Cole Avenue, Suite 300 Dallas, Texas 75204 214-661-5786

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice’s Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Room 509F, HHH Building Washington, D.C. 20201

**OUR RESPONSIBLITIES**

Premier Mental Wellness is required by law and regulation to protect the privacy of your health information, to provide you with this notice of your privacy practices with respect to PHI, and to abide by the terms of the notice of privacy practice in effect.

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**REVIEW ACKNOWLEDGEMENT OF NOTICE OF PRIVACY POLICES AND PRACTICES**

**Angel L.A.Adams, MSN, APRN, PMHNP-BC**

I have reviewed Premier Mental Wellnesses Notice of Privacy Practices, which explains how my health information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

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Name of Patient or Personal Representative Date

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Signature of Patient or Personal Representative Description of Personal Representative’s Authority

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Witness Date

**Premier Mental Wellness Group Office Policies**

**Appointments: \_\_\_\_\_\_\_\_(initial)**

* Our office hours are 9:00am to 4:00pm of Fridays. Patient appointments are scheduled by calling during regular office hours.

**Financial Policy: \_\_\_\_\_\_\_(initial)**

* An estimated payment is due at time of service by cash, Visa, MasterCard, Discover, or American Express. Depending on the level of service provided there may be an additional fee that is patient responsibility to pay within 30 days of receipt of our statement.
* Any balance on an account greater than 30 days old is considered past due. A statement will be mailed on a monthly basis and will reflect the current balance for all services rendered prior to the date on the statement. Payment is due upon receipt of statement.
* Payment plans are offered upon request.

**Red Flag Policy: \_\_\_\_\_\_\_\_(initial)**

* “Premier Mental Wellness must collect and store our patients’ private medical, financial, and personally identifying data. We must therefore be vigilant in protecting the patient information to which we have access including medical, financial, and any other personal information contained in Premier Mental wellnesses medical, appointment, or billing records.”
* You must present a valid state issued photo identification card prior to being seen at each appointment.
* If you would like us to bill your insurance carrier, you must present a valid insurance card prior to being seen at each appointment, or payment in full will be required.

**Miscellaneous Charges: \_\_\_\_\_\_\_\_(initial)**

* For charts or paper format, you will be charged $25.00 for the first 20 pages and .50 for each page thereafter. For records in electronic format you will be charged $25.00 for 500 pages or less and $50.00 for more than 500 pages and may take up to 15 business days to obtain. Report preparation fees are based on the time involved.
* Any returned checks are subject to a $30 service fee. Any returned check must be resolved before any future appointments can be arranged.
* ***If you do not cancel your appointment 24 hours in advanced, our policy is to charge the rate of $50 and is payable prior to future visits.*** These will not be billed to your insurance company. Please help us to serve you better by keeping your scheduled appointments or canceling in advance.

**Refill Requests/Messages: \_\_\_\_\_\_\_\_(initial)**

* All request for prescription refills must be made 48 business hours in advance.
* You may have your pharmacy request a refill.
* Any phone messages left after 2:00pm on Monday through Thursday will be returned the next business day. Any phone messages left after 2:00pm on Friday will be returned the following Monday.

**Emergency Situations/ After Office Hours: \_\_\_\_\_\_\_\_(initial)**

* Medication refills are only addressed during office hours.
* In an emergency, call 911 or go directly to the nearest emergency room.

**Cellular devices, camera, camcorders or any other recording/phot taking devices are prohibited: \_\_\_\_\_\_\_\_(initial)**

* To reduce the potential risk of a Federal HIPAA Violation recording and/or photo taking devices are prohibited, including but not limited to: cellular devices, camcorders, recorders.

**Fee Disclosure Acknowledgement: \_\_\_\_\_\_\_\_(initial)**

* We will make available our fee schedule for procedures upon request. Most fees are for office and/or hospital procedure. However, fees will also be incurred when you request services in addition to your regular services. **These fees may not be payable by your insurance plan and are to be paid at the time services are rendered**.

**The following is a brief, non-comprehensive listing of such services:**

1. Medical records process for transfer 25.00 and up
2. Returned checks (NSF) 30.00
3. Letters to employer, school, etc. 25.00 and up
4. Disability forms, letters, etc. 25.00 and up
5. Missed scheduled appointment 50.00
6. Canceled scheduled appointment with less than 24 hour notification 50.00
7. Medically necessitated and clinically indicated telephone appointment 110.00

**I have read and understand the Office Policy, and I agree to accept responsibility as described above. I also understand the Office Policy may be amended or modified from time to time by the practice. I am expressing my understanding by initialing next to each item on this page as well as signing below. If you have any question, please feel free to ask our staff for assistance. Thank you for choosing us for your care.**

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Patient Name (Please Print) Date

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Signature of Patient/Parent/Guardian/Representative Relationship to Patient