



MetPsych

1212 Spruce Street, Suite 315
Belmont, NC 28012
Phone: 704-461-8253
Fax: 704-461-8267

Metrolina Psychotherapy Associates, P.A.

Notice of Privacy Practices

This Notice is effective 7/1/10

THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

YOU WILL BE PROVIDED A COPY. PLEASE REVIEW IT CAREFULLY.

****We are required by law to protect health care information about you.****

The following information is provided to you as we are required by law to do so; and we desire to provide you services while you are in full understanding of the legal aspects of doing so. We aspire to protect your health care information and information that may identify you. Please know and understand that we are legally bound to the information provided to you in this document. We are only allowed to use and disclose health care information in the manner that we have described in this notice.

The officials of Metrolina Psychotherapy Associates, P.A. want you to feel comfortable asking questions about anything unclear to you in this notice. Please do so by contacting the privacy officer or the owner of this corporation.

Information regarding your health care at Metrolina Psychotherapy Associates, P.A. is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 (HIPPA), and 42 USC 1320 et seq., 45 CFR Parts 160 & 164 and, when applicable, Federal Drug and Alcohol Confidentiality, 42 USC 290dd-2, 42 CFR Part 2; and North Carolina Mental Health, Developmental Disabilities and Substance Abuse Laws (NCGS 122-C-52 through 122C-56).

Under these laws, Metrolina Psychotherapy Associates, P.A. may not say to a person outside this agency that you attend the agency, nor disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected health information except as permitted by the state and federal laws listed above or with your written authorization.



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I. We use and disclose health care information about you for **treatment, payment, and healthcare operations.**

A. **Treatment**

We may use and disclose health care information about you to provide health care treatment to you in order to provide, coordinate or manage your health care and related services. This may include communicating with other health care provider's within this corporation and with providers the corporation contracts with to provide services to you regarding your treatment and coordinating and managing your health care; unless otherwise specifically requested by you.

We may use and disclose health care information about you in order to inform you of, or recommend new treatment, or different methods for treating a health care condition that you have, or to inform you of other health – related benefits and services that may be of interest to you.

B. **Payment**

We may use and disclose health care information about you with your written consent to obtain payment for health care services that you received. This includes disclosing protected health information to your health insurer to obtain reimbursement and / or determine eligibility or coverage.

C. **Health Care Operations**

Health care operations include a variety of business activities. These activities include: providing training programs to other professionals or providers; business audits and other administrative services; planning for our organization's future services; and; working with other professionals such as lawyers, accountants, or other consultants.

D. **As Required by Law**

These laws are cited and explained within this notice. For instance, in the event that abuse and / or neglect of a minor or elderly person are known by your therapist or doctor. See II C.

E. **Persons Involved in Your Care**

We may disclose information about you to a relative, close personal friend or any other person you identify and consent to in writing if that person is involved in your care (or responsible for your care) and the information is relevant to your care. We may contact you to provide you notice of your next appointment or circumstances that may require rescheduling or changing of your appointment.



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II. Uses and Disclosures **without consent** or Authorization

The laws cited previously designate certain situations as “national priority.” This refers to insurances deemed important to disclose health care information without consent. They are:

A. Threat to health or safety

When it is necessary to prevent or lessen a serious threat to your health and safety or the health and safety of someone else. This also applies when we need to report a crime against our personnel or medical personnel in a medical emergency.

B. Public Health Activities:

These activities include, but are not limited to, activities related to investigation of disease, reporting child abuse and neglect, monitoring drugs or devices regulated by the FDA, and monitoring work related illnesses or injuries. For example, if you have been exposed to a communicable disease (such as sexually transmitted disease), we may report it to the State and take other actions to prevent the spread of the disease.

C. Abuse, Neglect, or Domestic Violence:

We are required by law to inform a governmental authority (such as the Department of Social Services) if it can be reasonably believed to be a situation where a child or elderly adult has been neglected, abused, or a victim of domestic violence.

D. Court Proceedings:

When a valid court order from a judge is presented Metrolina Psychotherapy Associates is forced to disclose health care information about you.

E. Law Enforcement:

If a law enforcement officer has a court order to take you into custody; (for example during an involuntary commitment for mental health needs), we are permitted to disclose to the officer information about your mental state when necessary to assure your health and the safety of others.

F. Coroners and others:

We are permitted to disclose health care information to a coroner or medical examiner which may be relevant to determine the cause of death and manner of death when required by law to do so.



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G. Workers Compensation:

We may disclose health care information about you in order to comply with workers' compensation law.

H. Research:

Metrolina Psychotherapy Associates, P.A. (if engaging in research), will only disclose protected health care information when stringent conditions about protecting the privacy of the information are satisfied.

III. Uses and Disclosures Requiring Consent / Authorization

Most of the information that is in your medical record with us is protected and illegal for us to share with anyone. If you are a minor we are permitted to share the information only with your legal guardian. Please also note though, that when you are a minor we are not allowed to share any information about substance use / abuse, even with your guardian.

A. Authorization:

In order for us to share information other than for the reasons listed above we are required to obtain your signature or the signature of your legal guardian that includes specific information about how, why, when, and what we will disclose. This is the case for when we want to release information or in the case you want us to disclose information.

B. Revocation of the Authorization:

You may revoke the above authorization at any time after you sign it. This must be done in writing via a letter or memo with your signature included.

IV. Client's Rights and Metrolina Psychotherapy Associates, P.A. responsibilities

A. Your Rights (client's rights):

1. Right to a copy of this notice.
2. Right of Access to Inspect and Copy: You have a right to review and receive a copy of your health information that we maintain in certain groups of records. This right can be denied if it is deemed that the information or part of the information will place you or someone else at risk for harm. This right may also be denied if the information was received from someone else, other than a health care provider, if he or she requested that it remain confidential. If this denial occurs you may require the request be reviewed by the corporation privacy director or the corporation owner. We must respond to this request in writing within 30 days of receipt of the request.
3. Right to have health care information amended: You have the right to question the accuracy and completeness of health care information about you that we maintain in certain groups of records and have the right to have us amend (correct or add to): the health care information. This must be requested in writing. We must act on this request within 60 days after the receipt of the request.



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4. Right to have an accounting of disclosures we have made: You have the right to receive a detailed list of disclosures we have made for the previous six (6) years of the day's date of request.
 5. Right to Request Restrictions: You have the right to request further limitation to the use of your protected health information; though please note, we are not required to agree to this request (though we will reasonably do so.)
 6. Right to request an alternative method of contact: You have the right to be contacted at a different location or by a different method. For example, you may prefer to have your bill be mailed to another address other than your home.
- B. Metrolina Psychotherapy Associates, P.A. responsibilities:**
1. We are required by law to maintain the privacy of your protected health information and provide you notice of our responsibilities and privacy practices.
 2. We have the right to change our privacy policies and practices. If we change them, we will provide you with an updated privacy notice on your next date of service, by mail, or in person whatever is sooner. Until you receive an updated privacy notice, we will follow the practices of this notice.
- V. You may file a complaint about our privacy practices.
- If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a complaint either with us or with the federal government. You may do this by contacting our privacy officer or the governmental authority you deem appropriate. The privacy officer can help you further with this should the need arise.



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RECIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of Metrolina Psychotherapy Associates' P.A. Notice of Privacy Practices.

Print Client's Name, or

Print Guardian Name

Signature

Date signed / received

The following is for Metrolina's internal use only

Metrolina Psychotherapy Associates, P.A. attempted to obtain acknowledgement of receipt of Notice of Privacy Practices. Acknowledgement could not be obtained as specified below:

_____ Individual refused to sign.

_____ An emergency situation prevented obtaining the acknowledgement. The Notice of Privacy Practices will be provided and acknowledgment obtained as soon as it is reasonably practicable to do so.

_____ Other (Please specify):

_____ Individual agreed for Metrolina Psychotherapy Associates, P.A. to mail a copy of the Notice of Privacy Practices. Record date, address and to who the Notice was mailed:

Staff Signature: _____

Date: _____