Brain Health Center, LLC
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Building 2, Suite 1
Wall, NJ 07719
848-404-9111 (phone)
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Notice of Privacy Practices

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, Brain Health Center will disclose no information about you, or the fact that you are a client, without your written consent. Your formal Mental Health Record describes the services provided to you and contains the dates of your sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. We will require your permission in order to communicate with your insurance provider, other health care providers or any third person. You may provide that authorization either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting your counselor.

II. Limits of Confidentiality

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality. The counselor may use or disclose records or other information about you without your consent or authorization in the following circumstances:

A· Emergency: If you are involved in in a life-threatening emergency and the counselor cannot ask your permission, the counselor will share only that information about you that is necessary to address the emergency.

B· Child Abuse Reporting: If the counselor has reason to suspect that a child is abused or neglected, the counselor is required by law to report the matter immediately to the New Jersey Department of Children Protection and Permanency.

C. Adult Abuse Reporting: If a counselor has reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, that counselor is required by law to immediately make a report and provide relevant information to the County Elderly Protective Services agency.

D. Court Proceedings: Your records or my testimony can be required by a judge's Court Order in a legal proceeding. Your records may be utilized in any proceeding brought by you against the counselor or Brain Health Center.

E. Serious Threat to Health or Safety: In the event that you pose a serious threat to a third person, the counselor is required to take actions to protect that person including warning him/her. If you pose a serious and imminent threat to yourself, the counselor is required to take action to protect you.

F: Records of Minors: Parents of minors (under the age of 18) have a legal right to access the records of their minor children. While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For minors 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Patient's Rights and Provider's Duties

A. Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

B. Right to Receive Confidential Communications by Alternative Means and at Alternative Locations — You have the right to request and receive confidential communications of personal health information (PHI) by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

C. Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process

D. Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information a fee of $1.00 per page for costs of copying and/or mailing will be assessed. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

E. Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

F. Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE: November 1, 2015

Client's Acknowledgement of Receipt of Notice of Privacy Practices

Please sign, print your name, and date this acknowledgement form. I have access to and/or have been provided a copy of the Notice of Privacy Practices of Brain Health Center.We have discussed these policies, and I understand that I may ask questions about them at any time in the future.I consent to accept these policies as a condition of receiving mental health services.

Client signature: _____Date:_____

Printed client name:_____

If Minor:
Parent/Guardian signature_____Date_____

Printed Parent/Guardian name:_____Description: _____