

Kimberly Delaney, M.S., LMFT
Licensed Marriage and Family Therapist – LF00002667

9431 Coppertop Loop
Suite B
Bainbridge Island, WA 98110
Office: 206-780-7822

14535 Bel-Red Road
Suite B-200
Bellevue, WA 98007
Cell: 425-890-2352

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 of April 14, 2003, the Health Information Portability and Accountability Act of 1996 (HIPAA), requires that I provide you with information about how I use and protect the information you provide to me in the course of treatment. This Notice is a statement of my privacy policies and your rights under HIPAA.

Information that is included in your file:

Your file of “protected health information” includes all of the data I collect from you (address, telephone number, insurance information, history, medications and so forth), the progress notes I create during and/or after each session. The file also contains notes of any contacts with other persons, such as your doctor, and a log of all such “collateral” contacts.

How your information is stored:

All of your protected health information is stored in a locked file cabinet in my office, in a folder identified by your name. Only I have access to the keys to that file cabinet.

How your information will be used:

It is my policy to hold your information in strict confidentiality, and to use it only for purposes of your treatment. This means that I will not disclose any personal information, including the fact that you are receiving treatment, to anyone without your written permission (and the written permission of legal guardians of children under the age of 13). There are certain legally required exceptions to this policy:

1. I am required by Washington law to report to the appropriate authorities incidents of abuse of a child, elder, or vulnerable adult of which I become aware. It is my policy to discuss the necessity of disclosure with my client if at all possible before reporting.
2. If you are suicidal or in danger of hurting yourself, I am ethically obligated to notify the appropriate authorities in order to protect your safety.
3. If you threaten to harm another person, I have a duty to break confidentiality, warn that person, and warn the appropriate authorities.
4. In certain legal proceedings I may be required to reveal information in response to a court or administrative agency order, and in certain cases in response to a subpoena, discovery request or other lawful process.
5. Please be aware that both custodial and non-custodial parents may have access to the treatment records of their minor children (children under 18).
6. I have the right to disclose necessary protected client information in any legal proceedings involving my registration and/or license.
7. I may have to disclose certain protected client information in the course of an investigation by the Secretary of the Department of Health and Human Services regarding compliance with HIPAA.
8. I may be required to disclose certain protected client information for public health purposes, or in regard to communicable diseases.

In addition, I participate in consultation with other professionals. Any individual case information revealed in consultation is disguised to prevent identification of the client involved, and of course your name will never be used.

Electronic Billing by Insurance Providers:

In the case that I would submit billings to your insurance provider(s), this is completed either by USPS (mail), FAX, or electronically. Your authorization for me to bill your insurer(s) constitutes consent to this arrangement.

Clinician's duties:

I have the duty to protect the privacy of your client information as discussed above, and to provide you with this written description of my privacy practices and policies.

I must abide by my written privacy policies then in effect.

I may change my privacy practices or policies, but I must also revise the Notice and inform you of any change. Revised policies are effective for all protected client information, whether or not you are still in treatment with me. You may request a copy of my revised policies at any time, by providing your name and address.

Your rights under HIPAA:

You have the right to request that I restrict the use and disclosure of your protected health information for treatment, payment and health care operations. I am not required to agree to your restrictions, but I am bound by any agreements I do make with you in this regard. (Under Washington law, you have a right to request that I not keep notes of our sessions, other than a record that the session occurred. Please discuss this with me if you are interested in exercising this option.)

You have the right to request that I contact you by alternative methods and locations, instead of the standard practice of telephoning you at your home or office.

You have the right to inspect and obtain a copy of your official client record.

You have the right to amend information in your client record that you believe is erroneous.

You have a right to an accounting of disclosures of your private health information.

You have a right to receive a copy of this notice upon request.

If you believe that I have violated your privacy rights, you may file a complaint in writing with me, and/or with the Secretary of the Department of Health and Human Services. I will not retaliate against you should you file such a complaint.

You may contact the Department of Health at 360-236-4902, or by writing to Department of Health, Health Professions Quality Assurance Division, P.O.Box 47869, Olympia, WA 98504-7869. You can request a copy of the acts of unprofessional conduct, or access this information online at <http://www.leg.wa.gov/wsladm/rcw.hum>

I can be reached at 425-890-2352 or by email at kdelaney@peopleintransition.com
My mailing address is 14535 Bel-Red Road, Suite B-200, Bellevue, WA 98007.

Thank you!

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Privacy Practices

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Privacy Acknowledgement

By my signature on this page I acknowledge that I have received a copy of Kimberly Delaney's Privacy Policies, and that I have had an opportunity to review and ask questions about those policies. My signature indicates my consent for Kimberly Delaney to send receipts, billing statements, and scheduling information to me by email if I request this. My signature also gives my permission to engage in conversations by cellular phone, and is an acknowledgement that I have had the opportunity to ask questions regarding any confidentiality issues involved with these practices.

Client's signature Date

Client's signature Date

Therapist's signature Date

Thank You!