Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice covers all information in our written or electronic records which concerns you, your care and payments for your care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing your care, or manage some of our administrative operations.

Innersense Behavioral Health Services physicians, clinicians and staff may use and disclose medical information (protected health information or PHI) about an individual for:

a. Mental Health Treatment – i.e.; providing mental health care services, sending/coordinating care information with other health care providers caring for you, ordering and obtaining off site tests/results, writing prescriptions, etc.

b. Payment – i.e.; submitting insurance claims on your behalf for treatment rendered.

c. Health Care Operations – i.e.; internal business planning activities and quality of care evaluation.

Innersense Behavioral Health Services is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization, including, but not limited to:

a. Disclosures required by law

b. Disclosures to avert serious threats to health and safety

c. Disclosures with reference to Workers' Compensation or Food and Drug Administration

Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization. (Please see below for identifying persons to whom you would allow disclosures of otherwise protected information).

Innersense Behavioral Health Services may contact the individual to provide appointment reminders or Information about treatment or other health-related benefits and services that may be of interest to the individual or patient.

Innersense Behavioral Health Services will routinely contact patients via telephone or secured e-mail at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments, test results, etc.

Our patients have the following rights regarding their protected health information:

a. The right to request restrictions on certain uses and disclosures of protected health information. Innersense Behavioral Health Services is not required to agree to a requested restriction, however.

b. The right to receive confidential communications of protected health information, as applicable.

c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.

d. The right to amend protected health information, as provided in the Privacy Regulation.

e. The right to receive an accounting of disclosures of protected health information.

f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

Innersense Behavioral Health Services is required by law to maintain the privacy of the protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. Innersense Behavioral Health Services is required to abide by the terms of the Notice currently in effect. Innersense Behavioral Health Services reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains. SBHS will provide individuals or patients with a revised Notice by posting new regulations in each office.

Individuals may complain to Innersense Behavioral Health Services and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated.

Please provide the name(s) of person(s) if any, to whom you would permit Innersense Behavioral Health Services to disclose personal health information as necessary for your continued health care. Please also note if specific health care information cannot be disclosed (i.e.; test results, appointment information, etc.) Otherwise, we will disclose only what is necessary for your continued health care in accordance to the Privacy Policy.

List below those individuals (family, friends, interpreter services, etc.) you will allow disclosure of your personal health information from Innersense Behavioral Health Services as necessary during the course of your health care services:

Name and Relation (circle one) Allowed Disclosure(s) Please circle ALL or specify

Spouse: ____ All or Specify: _____________________________________

Family/Friend -Name _____________________________ All or Specify: _____________________________________

Family/Friend -Name ______________________________ All or Specify: _____________________________________

Family/Friend - Name _____________________________ All or Specify: _____________________________________

Family/Friend – Name _____________________________ All or Specify: _____________________________________

_____ Initial if you will allow interpreter services if necessary for communication with health care providers

_____ (Initial*) I acknowledge and understand that Innersense Behavioral Health Services ' policy is to send copies of test results and/or other medical information to physicians who either ordered the procedure/consult or are in need of this health information to ensure coordinated and effective diagnosis and treatment. i.e.; your designated primary care provider or physicians/dentist seen for consult/treatment. This policy is to only disclose specific information necessary for coordination of your health care or mental health treatment.*

List below physician providers who you DO NOT want specified private health information sent which could be sent in the usual course of facilitating or coordinating medical treatment.

DO NOT SEND PHI: Provider Name: _____________________ All or Specify _________________

DO NOT SEND PHI: Provider Name: _____________________ All or Specify _________________

_____ (Initial) *I acknowledge and understand Sterling Behavioral Health Services' policy to contact me by various means when necessary for my health care services which may include by home/work/cell phone, fax, and/or email. I also understand that private health information may be included in that communication to me.*

I DO NOT want Innersense Behavioral Health Services to use the following methods of communication which may include my private health information:

Please list: ____

I hereby acknowledge that I have read pages 1 and 2 of Innersense Behavioral Health Services Notice of Privacy Practices and received a copy (if requested).

Signature ____ Date _________________________

Printed Name ____