

KESSLER PSYCHOLOGICAL SERVICES, LLC.

NOTICE OF PRIVACY PRACTICES

To all clients:

The Health Insurance Portability and Accountability Act, commonly known as HIPAA, requires us to notify you of how your personal health information is used for your medical and health care, and for business and administrative functions. It requires that your information be kept confidential, and that we have your permission to use that information for any activities outside of the therapy sessions.

We are committed to keeping your personal information confidential. With your written permission, we may use and disclose your information for the purposes of treatment, payment and billing, and for various administrative operations. However, we will only release the smallest amount of information necessary for the purpose needed, and not any additional information. We may disclose this information in writing, orally, by electronic facsimile, or by mail to others.

We may use your personal health information to inform and consult with your physician or other therapist, confer with and refer to other health care providers, gather data, bill and obtain payment for services from your insurance company and for other similar purposes. There are some situations where we must, by law, provide your personal health information to others, such as abuse or neglect, law enforcement, judicial and administrative proceedings, health oversight activities, emergency situations, and those required by state or federal law, or as required by the Secretary of Health and Human Services.

The HIPPA requirements give you certain "rights" as well, including the right NOT to allow us to use this information. You may restrict to whom the information is released if it is not to someone or to an organization involved in your health care. You have the right to have access to your own records, the right to request changes in the information if you feel it is in error, the right to know to whom the information is released, and the right to file a complaint if you feel your information was used inappropriately.

We ask for your signed permission to use your personal information and for your acknowledgement that you have received this notification. Please sign below and retain a copy of this notice for your records. A copy will be placed in your record. Thank you for your cooperation.

If you believe your privacy rights have been violated, you have the right to file a complaint with the Secretary of the Department of Health and Human Services, 200 Independence Ave., S.W. Room 509F, HHH building, Washington, D.C. 20201

The following paragraph will be included in any emails, letters, or facsimiles we may transmit:

This message and any included attachments are intended only for the addressee. The information contained in this message is confidential, private and may constitute proprietary or non-public information under federal or state laws. Unauthorized forwarding, printing, copying, distribution, or use of such information is strictly prohibited and may be unlawful. If you are not the addressee, please promptly delete or destroy this message and notify sender of the delivery error by email, letter, or facsimile.

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

NAME: _____

BIRTHDATE: _____

My signature documents that I have received the "Notice of Privacy Practices" from this office and that I agree with its contents.

Signature

Date