BREAKTHROUGH
COUNSELING · COACHING · CONFLICT MANAGEMENT

Breakthrough Counseling & Coaching
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HIPAA NOTICE OF PRIVACY PRACTICES

I. This notice describes how medical and mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

II. It is my legal duty to safeguard your protected health information (PHI).

These practices are in compliance of state and federal statutes and regulations including Federal Regulation 42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA, 45 C.F.R. Parts 142, 160, 162 and 164.

By law I am required to ensure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future physical and mental health or condition, the provision of health care services to you, or the payment for such health care. PHI also includes information related to your services and payment for services. HIPAA and federal law regulate the use and disclosure of PHI when transmitted orally, written, and electronically.

I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Given the nature of Sonjia Serda's (dba Breakthrough Counseling) nature of work, it is imperative that is maintains the confidence of client information that it receives during its work. Breakthrough Counseling is a mental health counseling practice that prohibits the release of any client information to anyone outside immediate staff, employees, interns, and/or volunteers except in limited circumstances in accordance with this Notice of Privacy Practices. Discussions or disclosures of protected health information within the organization are limited to the minimum necessary that is needed for the recipient of the information to perform his/her job.

Please note that I reserve the right to change the terms of this Notice if state and federal policies change. If I make changes, I will post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. **For treatment.** I may disclose your PHI for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors

or other treatment team members and for coverage arrangements during my absence and for sending appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. **For health care operations**. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I follow applicable laws.
3. **For payment.** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
4. **Other disclosures/emergencies**. Examples: Your consent isn't required if you need emergency treatment if I attempt to get your consent after treatment is rendered. In the event that I try to get your consent, but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.
5. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
6. **If disclosure is required by a search warrant/affidavit lawfully issued to a governmental law enforcement agency.**
7. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (CRS 12-43-218). If I suspect child neglect, abuse, domestic abuse, or elder neglect or abuse, adult dependent abuse, or other forms of exploitation, such as kidnapping, sex trafficking, I am required to notify appropriate authorities.
8. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
10. **For public health activities**. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. **For health oversight activities.** Example: I may be required to provide information to assist the government during an investigation or inspection of a health care organization or provider such as COVID-19 or other transmittable disease.
12. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
13. **I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that may be of interest to you.**
14. **Crimes on the premises or observed by the provider**. Crimes that are observed by the provider or the provider's staff, crimes that are directed toward the provider, the provider's staff or others, crimes that occur on the premises will be reported to law enforcement.

15. **Involuntary clients.** Information regarding clients who are being treated involuntarily pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others as necessary to provider the care and management coordination needed.
16. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.

B. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations. This includes your emergency contact information.

C. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI. These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see and request a copy of your PHI that is in my possession, however, you must request it in writing. You will receive a response from me within 30 days of my receiving your written request. I may charge a reasonable cost-based fee to fulfill your request. Under certain circumstances, I may feel I must deny your request, in part or in whole, if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you $.40 per page. With your written permission, I will provide you with a summary or explanation of the PHI and charge a nominal fee.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience and in a secure method to the degree possible.

D. Limits on what I use or share. You may request me not to use or share certain health information for treatment, payment, or my business operations; however, I may decline your request if it would affect your care. If you pay for a service out-of-pocket in full, you can ask me to not share that

information for the purpose of payment or my operations with your health insurer. I will agree unless a law requires me to share that information.

E. Get a list of those with whom your health information was shared. You may request a list of whom, why and how many times, your health information for 6 years prior to the date you ask was shared. All disclosure will be given to you except those about treatment, payment, and health care operations, and certain other disclosures. I'll provide one list a year free of charge, requests outside this time frame will incur a cost-based fee.

F. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. I may deny your request if I find that: the PHI is (a) correct and complete, (b) not part of my records, or (c) written by someone other than me. If I deny this request, an explanation will be provided in writing within 60 days.

G. Power of Attorney. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information, upon confirmation that they hold such authority.

V. SPECIAL AUTHORIZATIONS. Certain categories of information have extra protections by law, and this requires special written authorization for disclosures.

A. Psychotherapy Notes: Sonjia Serda may keep and maintain psychotherapy notes which may include but are not limited to notes I made about your conversations during a private, group, joint, or family counseling session, which is kept separately from the rest of your record. These notes are given a greater degree of protection than PHI. These are not considered part of your "client record." I will obtain a special authorization before releasing your psychotherapy notes.

B. HIV or other communicable disease: Special legal protections apply to HIV/AIDS related information. I will obtain a special written authorization from you before releasing information related to HIV/AIDS.

C. Alcohol and Drug Use Information: Special legal protections apply to information related to alcohol and drug use and treatment. I will obtain a special written authorization from you before releasing information related to alcohol and/or drug use/treatment.

D. Revocations of authorizations: You may revoke all such authorizations to release information at any time, provided each revocation is in writing, signed by you, and signed by a witness. You may not revoke an authorization to the extent that (1) I have already relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

VI. OTHER PROVISIONS UNDER THE PRIVACY AND SECURITY RULES: Sonjia Serda, LPC is required to reasonably safeguard PHI from impermissible uses and disclosures. Safeguards may include, but are not limited to the following:

A. Not leaving test results unattended where third parties without a need to know can view them.
B. Any PHI received as a Breakthrough Counseling employee, intern, or volunteer about a client or potential client, may not be used or disclosed for non-work purposes or with unauthorized individuals.
C. When speaking with a client about his/her PHI where third parties could possibly overhear, the conversation will be moved to a private area.
D. Seeking legal counsel in uncertain situations and/or incidences.
E. Obtaining a Business Associates Agreement with those third parties that have access to and/or store client information, as required by law.
F. Implementing FAX security measures.
G. Obtaining your consent prior to sending any PHI by unsecure electronic transmissions.
H. Providing information on Sonjia Serda's electronic record-keeping devices.

VII. HOW TO COMPLAIN IF YOU FEEL YOUR RIGHTS ARE VIOLATED.

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the U.S. Department of Health and Human Services at 200 Independence Avenue S.W., HHH Building, Washington, D.C. 20201 or call 1-877-696-6775 or visit hhs.gov/ocr/pricacy/hipaa/complaints/. If you file a complaint, I will take no retaliatory action against you.

You may also file a complaint with the WY Professional Licensing Board, wyomhplb@wyo.gov or 307-777-7788, Cheyenne, WY.

If you have questions or complaints about this Notice, please contact the Privacy Officer, Sonjia Serda at 307-514-2781.

VIII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on March 27, 2020. The complaint privacy officer for this office is Sonjia Serda. She can be reached at 307-514-2781.

ACKNOWLEDGEMENT OF RECEIPT OF THE HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of this notice

Patient Name: _____ Date: _____ Signature: _____

Patient Name: _____ Date: _____ Signature: _____

Breakthrough Counseling & Coaching
Sonjia Serda, LPC #918

1616 East 19th Street, Suite 1
Cheyenne, WY 82001
307-514-2781

FORM D
HIPAA NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT TO DECLINE COPY OF HIPAA NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date: _____

Signature: _____

_____ Date: _____
If not client, relationship to client(s)