# WHAM COUNSELING, LLC

# ACKNOWLEDGEMENT OF PRIVACY PRACTICES

**I understand that under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to : guide, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in my treatment directly and/or indirectly; receive payment from third party payers; perform normal healthcare operations such as quality assessments and physician certifications.**

**I understand that, as required by law, my clinician may release information related to abuse or neglect with children or vulnerable people; threats to self or others or under court orders.**

**I have read, received and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that my clinician has the right to change its Notice of Privacy Practices from time to time and that I may contact my clinician at any time to receive a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment and healthcare options. I also understand you are not required to agree to my requested restrictions, but that if you do agree you are bound by the restrictions.**

**I understand the following forms- Consent for Mental Health Services, Acknowledgement of Privacy Practices and Payment Policy and Agreement- and I have had an opportunity to ask questions about any of them.**

**Patient Name:** _____ **Date:** _____

**Patient/Parent/Guardian Signature:** _____

**Witness (therapist)** _____ **Date:** _____

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**As a part of HIPAA Privacy rule, we need you to tell us how you wish to be communicated with:**

**Email address:** _____

**Cell Phone:** _____ **Home Phone:** _____

**Where would you like to receive appointment reminders?**

_____ **Via text message on my cell phone (normal text message rates apply)**

_____ **Via an email message to the address listed above**

_____ **Via an automated telephone message to my home phone**

_____ **None of the above**

**I understand that it is my responsibility to make my appointments. Missed appointment fees apply. Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.**

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**Signature**