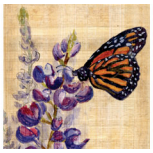


SHEILA SIMPSON-CREPS MA, LMHC, MFA
360-293-3489 Office: 1004 7th St. Anacortes, WA 98221
info@artwellspring.com www.artwellspring.com
Mail address: P.O. Box 83 Lopez Island, WA 98261

The privacy of your health information is important to me. I will maintain the privacy of your health information and I will not disclose your information to others unless you tell me to do so, or unless the law authorizes or requires me to do so.

A federal law commonly known as, HIPAA requires that I take additional steps to keep you informed about how I may use information that is gathered in order to provide health care services to you. As part of this process, I am required to give you the opportunity to read the attached Notice of Privacy Practices, provide you with a copy if you desire, and to request that you sign the form called ***Client- Therapist Agreement*** to acknowledge that you read and had the option of obtaining a copy of the Notice. The Notice describes how I may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information I maintain about you and a description of how you may exercise these rights.

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.

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

For more information about my privacy practices, or for additional copies of this Notice, please contact me using the information listed in Section II G of this notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. ***Permissible Uses and Disclosures without Your Written Authorization***

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. Treatment: I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment.

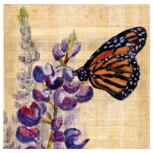
2. Payment: I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, the party/parties responsible for payment, which may include your health insurance plan.

3. Health Care Operations: I may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. Required or Permitted by Law: I may use or disclose PHI when I am required or permitted to do so by law. In addition I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

There are some times when the laws require us to use or share your information. *For example:*

1. When there is a serious threat to your or another's health and safety or to the public. I will only share information with persons who are able to help prevent or reduce the threat.
2. When I am required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.



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B. **Uses and Disclosures Requiring Your Written Authorization**

1. Psychotherapy Notes: Any notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization. As your therapist, I have the professional discretion to take—or NOT to take—such notes, always with the goal of better providing care for you and keeping in mind your particular needs as a client.

2. Marketing Communications: I will not use your health information for marketing communications.

3. Other Uses and Disclosures: Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can communicate PHI to your physician, or to a school. You may revoke any authorization you have given for such disclosures at any time.

I will never disclose the fact that I see you, or the content of our therapeutic work, to any court of law or attorney, unless my professional conduct is at issue, or unless required by law. *If your need for therapy includes having a therapist who will share information in court (e.g., in current or potential divorce proceedings, child custody cases, sexual abuse litigation, as proof of emotional/psychological injury after a car accident, etc.), or for other similar purposes, I ask that you seek another therapist. I believe strongly that disclosing information about your psychotherapy can be very damaging to your healing process. I will be happy to refer you to another appropriate resource, such as a therapist who specializes in child custody issues, forensic psychology, or other appropriate professional resource, whenever possible.*

II. HOW YOUR INFORMATION IS STORED:

1. I currently keep all client files locked in my office. I do bill some insurance companies electronically, using Office Ally, which is a billing clearinghouse that maintains HIPAA-compliant privacy and security standards. I keep copies of client claims on my computer for reference purposes, and delete old copies of claims periodically after resolution. I am the only person with access to my file cabinet keys. My computer is password protected, and any copies of claims are subject to a second password.

III. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request access to your medical record and billing records maintained by me in order to examine and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you. Please note that in Washington State, the age of consent is 13 years old for psychotherapy purposes. If a client is 13 or older, written authorization is necessary to disclose information, including billing information, to the parent or legal guardian.

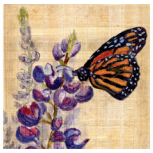
B. Right to Alternative Communications. You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations. I currently communicate with clients by phone/voicemail. *Email shall be used solely for establishing contact and arranging appointments, not for therapy* because I am not able to ensure the security of email and texting.

C. Right to Request Restrictions. You have the right to request a restriction on PHI used for disclosure for treatment or payment or health care operations. You must request any such restriction in writing addressed to me as indicated below. I am not required to agree to any such restriction you may request.

D. Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by me. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. Right to Request Amendment: You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to me at any time.



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G. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact me, Sheila Simpson-Creps at 350-293-3489. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the Director or myself.
I have printed a copy of the Washington State law regarding disclosure and will provide it to you at our first visit.

IV. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on January 1, 2015.

B. Changes to this Notice. I may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in my office. You may also obtain any revised notice by contacting me.

I am my own Privacy/Security Official. So, if you have any questions about this Notice of Privacy Practices, please contact me.
My contact information is:
Sheila Simpson-Creps
P.O. Box 83
Lopez Island, WA 98261

Date of NPP: _____

❑ Copy given to the client/parent/personal representative