Wellspring Psychological Services Phone: 650-429-8828

Caroline C. Fleck, PhD
Licensed Psychologist

451 N. Shoreline Blvd, Suite 1, Mountain View, CA 94043
drfleck@wellspringpsychologicalservices.com

Notice of Privacy Practices for Protected Health Information (PHI)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Effective date January 1st, 2019.

This notice details some of the ways in which your protected health information (PHI) may be used and disclosed. As a healthcare professional, I am required to give you this notice and abide by its terms.

In general, the communications between a client and psychologist are confidential and protected by law; I can only release your PHI with your permission, or under certain circumstances (see Uses and Disclosures). When I make a disclosure, I will try to limit the information that I reveal to the minimum amount necessary for communication.

I may, in some cases, take "psychotherapy notes," (private notes kept separate from your other healthcare information). Under most circumstances, use and disclosure of "psychotherapy notes" will require your authorization.

Uses and Disclosures

Generally speaking, I cannot disclose the information you share with me, unless provided with your written consent and authorization to do so. However, there are some circumstances in which state and/or federal law may permit or require me to disclose information from our work together. More details regarding these circumstances can be found in the Board of Psychology's Laws and Regulations (www.psychboard.ca.gov/lawsregs/index.shtml), and through the U.S Department of Health and Human Services (https://www.hhs.gov/hipaa/for-individuals/index.html). These circumstances include, but are not limited to:

1. If you have provided me with consent to disclose information.
2. If I need to speak with your physician or another treatment provider for the purposes of treatment or diagnosis. This includes, but is not limited to, emergency situations in which information must be shared with other health care providers in order to ensure your safety and protect you from immediate harm.
3. If you become unable to care for yourself, and/or threaten to do serious physical harm to yourself. In these cases, I may act to prevent you from injuring yourself and to ensure that you receive proper medical care.
4. If I have reasonable cause to believe that a minor, elderly adult, or disabled person of any age has been or will be the victim of physical abuse, sexual abuse, financial abuse, or neglect. In these instances, I am required to make a report to the appropriate authorities, and may have to contact the potential victim.
5. If your records are subpoenaed by the courts and/or if I am ordered to testify.
6. If you file legal or ethical charges against my practice, or me. In these cases, I maintain the right to provide information that may be necessary for my defense.
7. If necessary for payment. If you default on your payments or are behind on your bill, I reserve the right to refer your account to a collection agency.
8. If my services were sought or obtained to aid anyone to commit, or escape detection of, a crime.
9. If necessary for health care operations, including for the purposes of conducting quality assessment and quality improvement functions.
10. If you direct any threats of violence to me or my business associates; I reserve the right to communicate with the appropriate authorities under these circumstances.

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There are two additional situations in which I might discuss aspects of your case with another therapist:

1. When I am away from the office for an extended period of time, I usually have a colleague "cover" for me. This therapist will be available to you in emergencies. Therefore, he or she needs to know about you. This therapist is of course required to practice in accordance with the same laws and rules of confidentiality by which I abide. If you do not want me to disclose your information to my colleague, please tell me. If you do not state otherwise, your signature below constitutes your agreement with these practices.

2. Research consistently shows that case consultation is critical to providing high-quality treatment. As such, I consult weekly with a clinical consultation team of colleagues. If the individual with whom I consult is not among your treatment providers, I will not share your name or any other identifying information. I may tell you ahead of time if I intend to seek consultation about an aspect of your treatment, though I cannot ensure that this will always be the case. My colleagues are also required to keep your information private. If I do not hear otherwise from you, your signature below constitutes your agreement with these practices.

Disclosures beyond those permitted or required by law will only be made with your written authorization; you can revoke your authorization at any time by notifying me in writing, except to the extent that I have acted in reliance on your prior authorization.

Commercial and Fundraising Activities
If I wish to use your PHI for marketing purposes, your authorization is required. Similarly, if your PHI is ever sold, such a sale requires your authorization. I am permitted to contact you to remind you about appointments, to discuss treatment alternatives, or other health-related services that may be of interest to you. I can also contact you for fundraising activities related to my practice. You have the right to opt-out of receiving fundraising communications, should those communications occur. In such a case, the opt-out procedures will be disclosed with each fundraising communication.

Your Individual Rights

- Right to request restrictions: You can request that I restrict the disclosure of information such as I described above, but I am not required to agree to these restrictions. However, if I do agree to these restrictions I must abide by our agreement unless an emergency occurs. If I do have to disclose information in an emergency I will request to the persons to whom I make the disclosure that the information remain as confidential as possible. Any agreement that we make to restrict these disclosures will be written down and signed; if either of us needs to terminate our agreement, we will document our agreement in writing, and will each get a copy of the document. You cannot limit the uses and disclosures that I am legally required or allowed to make.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:
  If you wish to receive communications from me by alternative means (such as billing at a different address) you have the right to make reasonable requests. This is especially true if my usual means of communicating with you could endanger you or someone else. If you want to make such a request, please do so in writing and we will discuss if I can agree to your request.
- Right to Inspect and Copy: In most cases, you have the right to inspect and/or receive a copy of your medical and billing records. To do this, you must submit your request in writing. In situations in which more than one family member was part of treatment, no information regarding treatment will ever be disclosed at a later time, verbally or written, even upon written request from one of the parties to do so, without the written consent of all parties. If you request a copy or a treatment summary, I may charge a fee for the cost of copying and mailing, and/or for the

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time spent preparing a treatment summary. In rare circumstances, I may deny your request to inspect and/or copy records. In this case you have the right to require that I permit inspection of the records requested by, or provide copies to, a licensed physician or surgeon, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, or licensed professional clinical counselor designated by your written authorization.

- Right to Amend: If you believe that PHI I have about you is incorrect or incomplete, you may ask me to amend the information. Amendment requests must be made in writing. In addition, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that: 1) was not created by me (I will add your request to the information record); 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.
- Right to an Accounting of Disclosures: You have a right to receive an accounting of most of the disclosures of your PHI that have occurred in the last six years.
- Right to a Copy of this Notice: If I originally only provided you with an electronic copy of this document, you have a right to receive a paper copy of this notice upon request. I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future.

My Duties

- As explained above, I am required by law to maintain the privacy of your PHI, and to provide you with notice of my legal duties and privacy practices with respect to that PHI.
- I have a duty to notify you if there is a breach of your unsecured PHI.
- I have a duty to abide by the terms of the notice currently in effect. I reserve the right to change some of the terms of this notice. If/when that happens, the change will apply to all the PHI I possess, not just the information I possess following the date of the change. If changes are made, I will provide you with an updated copy of this notice and will explain the changes to you at your request.
- If you have a complaint about how I have disclosed or failed to disclose your PHI, you can make a complaint to me, or to the U.S. Secretary of Health and Human Services. If you wish to make a complaint to me, please put your concerns in writing and deliver them to me in person or via US Mail. I will not retaliate against you for filing a complaint.
- If you have any additional questions, you may contact me at my regular address, which is: 451 N. Shoreline Blvd, 94043. My telephone number is 650-429-8828.
- If you have paid out of pocket for my services (i.e., you have paid me directly in-full), I must restrict the disclosure of your PHI concerning those services for which you paid on an out-of-pocket basis. You can allow me to disclose that information if you wish.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (PHI), AGREE TO ITS TERMS, AND HAVE RECEIVED A COPY OF IT.

______________________________ ______________________________

Client's signature Date

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Printed name