CASSANDRA NEUHAUS, PSY.D., PLLC
NOTICE OF PRIVACY PRACTICES
Effective Date: January 1, 2019

THIS NOTICE DESCRIBES HOW YOUR PROTECTED MEDICAL INFORMATION MAY BE USED, DISCLOSED, AND HOW YOU MAY ACCESS, PROTECT, AND CONTROL YOUR INFORMATION. PLEASE REVIEW IT CAREFULLY.

Cassandra Neuhaus, Psy.D., PLLC creates and maintains a record of the services and treatment that you receive. This practice is a covered entity under the Health Insurance Portability and Accountability Act (HIPAA), as amended. Your medical records and billing information are systematically created and retained on a variety of media including computer, paper and film. That information is accessible to Cassandra Neuhaus, Psy.D., PLLC workforce and members of its professional staff; it may at times also be accessible to certain Business Associates during the diligent course of their duties. Although it is not impossible for unauthorized access to occur, proper safeguards and sanctions are in place to protect against improper use or access. I am required by law to protect your privacy and the confidentiality of your personal and protected health information and records. This Notice of Privacy Practices ("Notice") describes your rights and our legal duties regarding your protected health information.

DEFINITIONS: You may see or hear new terms in relation to this Notice. Some of these terms are listed below.

A. PHI or PROTECTED HEALTH INFORMATION is your personal and protected health information that I use to provide care and treatment service to you and to bill for the services provided.

B. BUSINESS ASSOCIATE is an individual or business independent of the practice that works on behalf of the practice to help provide you or the practice with services. For example, I may engage the services of an outside company to help with our compliance program, billing processes, medical files, and electronics to ensure I maintain compliance. I may also ask a physician to review our charts to review our performance and recordkeeping activities to make certain that I am providing the best possible care to our patients. I may also use your names and address to market our services in the form of practice newsletter or other correspondence that I feel may be of interest or benefit to you. Contact me if you would prefer to opt out of any marketing programs.

C. AUTHORIZATION I will obtain an authorization from you when required giving me permission to use of disclose your protected health information for purposes other than for your treatment, to obtain payment of your bills and for healthcare operations of the practice.

TREATMENT, PAYMENT, and HEALTH CARE OPERATIONS

I may use and disclose your protected health information without your authorization for treatment, payment, and healthcare operations:

1. TREATMENT A facility and its professional staff may use protected health information about you to provide you with medical treatment or services. I may disclose protected health information about you to doctors, nurses, technicians or interns who may be involved in your care at our facility or another service site. For example, I may participate in a Health Information Exchange ("HIE") with community healthcare providers and health plans, using confidential electronic network organization to facilitate your treatment through the exchange of patient health information. This secure network provides safer, more effective care tailored to a patient's specific needs. You have the right to block your information from being shared with other participants of the HIE by signing an opt-out form upon request. I may disclose your health information to your primary care or other physician about your treatment.

2. PAYMENT A facility and its professional staff may ordinarily use and disclose protected health
information about you so that the treatment and services you receive at the facility or by professional staff or business associates may be billed to and payment may be collected from you, your health plan or a designee. For example, I may need to provide your health plan information about future treatment in order to obtain prior authorization.

3. HEALTH CARE OPERATIONS A facility and its professional staff may use and disclose protected health information about you for the organizational operations. These uses and disclosures may be necessary to electively manage the practice and to ensure the highest quality of services to its patients. For example, I may use protected health information to review our treatment and services, to evaluate the performance of staff and to business associates in caring for you and to train other professionals. I may also combine protected health information from our practice with protected health information from other facilities to evaluate our effectiveness and for possible process improvement for the benefit of our patients. I may provide your protected health information directly to your health plan or through a HIE, describe above, for its quality assessment and improvement activities, outcomes evaluation and for other healthcare operation purposes.

4. BUSINESS ASSOCIATES A facility and its professional staff may disclose your health information to Business Associates separate or independent of the facility with whom I or they contract to provide services on our or their behalf. However, I will only make these disclosures if I have received satisfactory assurance that the business associate will properly safeguard your privacy and the confidentiality of your protected health information. For example, I may contract with a separate company for billing, compliance, account collections or for computer work. I may also provide medical records to legal counsel for consultation and assistance with claims or disputes.

DISCLOSURES NEEDING YOUR CONSENT OR PERMITTING YOUR OBJECTION

5. APPOINTMENT REMINDERS A facility and its professional staff may use and disclose your protected health information to contact you as a reminder that you have an appointment for treatment at the facility or at your home. This may be done through an automated system or by one of our staff members. If you are not at home, I may leave this information on your answering machine or with the person answering your phone. You have the right to stop appointment reminders if you inform me in writing of your decision.

6. HEALTH RELATED BENEFITS AND SERVICES A facility and its professional staff may use and disclose your protected health information to tell you about health related benefits or services or recommend possible treatment options or alternatives that may be of interest to you.

7. INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE The facility and its professional staff may release protected health information to a friend or family member who is involved in your medical care. I may also give protected health information to someone who pays for your care. You may object to disclosure to these individuals by notifying me.

SPECIAL SITUATIONS WHERE DISCLOSURE MAY OR MAY NOT REQUIRE YOUR CONSENT

8. RESEARCH Under certain circumstances, the facility and its professional staff may use and disclose protected health information about you for research purposes. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of protected health. Before I disclose medical information for research, the project will have been approved through a research approval process, and your authorization will generally be required, but I may, however, disclose protected health information about you to researchers preparing to conduct a research project, for example to help the determine patients with specific conditions or needs. I will generally ask for your authorization if the researcher(s) will need access to your names, address or other information that reveals your identity, or will be involved in your treatment.

9. AS REQUIRED BY LAW The facility and its professional staff will disclose protected health
information about you when required to do so by federal, state or local law.

10. TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY The facility and its professional staff may use and disclose protected health information about you when necessary to prevent a serious threat to your health or safety and the safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

11. PUBLIC HEALTH REPORTING The facility and its professional staff may use and disclose protected health information about you for public health activities required by law. For example:

- To prevent or control disease, injury or disability;
- To report child abuse or neglect; child pornography, elder abuse or neglect or abuse or neglect to any disabled individual;
- To report reactions to medications or problems with products;
- To notify people of recalls to products they may be using;
- To notify the Oklahoma State Department of Health that a person may have been exposed to a disease or may be at risk for contracting or spreading a disease such as HIV or other sexually transmitted disease;
- To notify the appropriate government authority of I have legitimate reason to believe that a patient has been the victim of domestic violence.

12. HEALTH OVERSIGHT ACTIVITIES The facility and its professional staff may use and disclose your protected health information to a health oversight organization for activities necessary for the government to monitor the health care system, government programs, and compliance with applicable laws. These activities include, for example, audits, investigations, inspections, medical device reporting to manufacturers, agencies and licensure entities and compliance with other laws such as civil rights laws.

13. LAWSUITS AND DISPUTES The facility and its professional staff may use and disclose your protected health information about you in the course of judicial or administrative proceedings in response to a court or administrative order. Except as may be prohibited by law, I may also disclose protected health information about you in response to a subpoena, discovery request, or other lawful process. I will make reasonable efforts to notify you or your attorney about the request or obtain an order protecting the information requested. For certain categories of medical information, patient authorization may be required for release.

14. LAW ENFORCEMENT The facility and its professional staff may use and disclose your protected health information about you if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person;
- About the victim of a crime if, under certain limited circumstances, I am unable to obtain the person’s agreement;
- About a death I believe may be the result of criminal conduct;
- About criminal activity at the facility;
- In emergency circumstances to report a crime.

15. CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS I may release protected health information to Coroners and Medical Examiners. This may be necessary in the event of a death of a death to identify the individual or to determine cause of death. I may also need to disclose protected health information to funeral directors as necessary so they may conduct their professional duties.
YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION

You have the following rights regarding protected health information that I maintain about you.

1. RIGHT TO INSPECT AND COPY You have the right to inspect and request a copy of your protected health information in the "designated record set," except as prohibited by law. The "designated record set" is the medical and billing records used to make decisions in your care, as determined by the practice. You also have the right to authorize third parties to obtain your protected health information.

To inspect, by appointment, and/or to request a copy of your protected health information you must submit a request in writing on an approved Authorization Form. These forms are available upon request. I may charge a fee to offset the costs associated with the request.

I have the right to deny your request to inspect and copy in certain circumstances. If you are denied access to certain protected health information, you may request that the denial be reviewed. Some types of records may be denied for personal safety or potential harm reasons, but you may obtain a review of this denial. An independent health care or legal professional chosen by the practice will review your request and the denial. The person conducting the review will not be the same person who denied the request. I will comply with the decision of the independent reviewer.

You have the right to revoke in writing an Authorization, but prior disclosures will not be effected.

2. RIGHT TO AMEND If you feel that protected health information in a designated record set I have about you is incorrect or incomplete, you may ask the facility to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. To request an amendment, your request must be made in writing and must state the reason for the request. A form for this purpose is available upon request. Submit your request to the Office Manager. I may deny your request for an amendment if it is not in writing or does not include the reason to support the request. In addition, I may also deny the request if you ask me to amend information that:

- Was not created by me, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the protected health information kept by or for the facility;
- Is not part of the information which you would be permitted to inspect or copy; or
- Is accurate and complete.

If I deny your amendment, you may request a concise statement be added to your chart describing the entry you believe is incorrect and what you believe is accurate. I reserve the right to edit any extraneous comments other than the statement of objective information.

3. RIGHT TO ACCOUNTING OF DISCLOSURES You have the right to request one free accounting for every twelve months of certain disclosures a facility made of protected health information about you to third parties or agencies, unless those disclosures were made for treatment, payment or healthcare operations or were subject to Authorization. To request this accounting, you must submit your request in writing to the medical records custodian. A form for this purpose is available upon request. Your request must state a time period, which may not be longer than six years. Your requests should indicated in what form (paper or electronic). For additional lists, I may assess a fee for the cost of providing the list. I will inform you of the cost and you may choose to withdraw or modify your request before charges are assessed.
4. **RIGHT TO REQUEST RESTRICTIONS** You have the right to request a restriction or limitation on the protected health care information a facility uses or discloses about you for treatment, payment or healthcare operations. You also have a right to request a limit on the protected health information I disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you may request that I not disclose information about specific medications or treatments. You may also request that I do not disclose certain information to your health plan if you are not filing a claim for a specific procedure or treatment.

In certain situations, I am not required to agree with your request. If I do agree, I will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions, your request must be in writing. A form for this purpose is available upon request. In your request you must inform me of the following:

- What information you want to limit;
- Whether you want to limit our use, disclosure or both;
- And to whom you want the limits to apply.

5. **YOU HAVE THE RIGHT TO BE NOTIFIED CONCERNING UNAUTHORIZED USE OF DISCLOSURE** In the event of an unauthorized use or discloser, or breach of security, in which it is probable your protected health information has been compromised, you have the right to a written notification explaining the breach, what has been done about the breach and what you may do to protect yourself.

6. **YOU HAVE THE RIGHT TO CONFIDENTIAL COMMUNICATIONS** You have the right to request that a facility communicate with you in a certain way or at certain location. For example, you may request that I contact you only at home or by mail. To request confidential communications, you must make your request in writing to Dr. Neuhaus. I will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. A form is available from the office for this purpose.

7. **RIGHT TO A PAPER COPY OF THIS NOTICE** You have the right to a paper copy of this Notice at any time from the office. It is also available electronically.
RESERVATIONS ABOUT THIS NOTICE

I reserve the right to change this notice at any time. I reserve the right to make the revised or change Notice effective for protected health information I already have about you as well as any information I receive in the future. I will post a copy of the current Notice in our facility. The Notice will contain on the first page, near the top, the effective date. In addition, each time you check in at the facility for treatment I may not offer a Notice to you if you have already received a current version, but I will provide another copy upon request.

AUTHORIZATION FOR OTHER USES OF PROTECTED HEALTH INFORMATION

Other use and disclosures of protected health information not covered by this notice or the laws that apply to me will be made only with your written authorization. You may revoke an authorization at any time, but prior release of information will not be affected.

QUESTIONS, REQUESTS, COMPLAINTS

If you have a question or request, you may contact Dr. Neuhaus. If you feel your privacy rights have been violated, you may file a written complaint with the facility with the Secretary of the Department of Health and Human Services. You cannot be retaliated against for filing a complaint. You may also request a form specifically for this purpose at our office.

To file a complaint with our facility, submit it to Dr. Neuhaus:

Cassandra Neuhaus, Psy.D., PLLC
5800 E. Skelly Drive, Suite 1111
Tulsa, Oklahoma, 74135
Phone: 918-409-0741
Fax: 918-209-5538

To file a complaint with the U.S Department of Health and Human Services:

Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX, 75202
Phone: 800.368.1019
Fax: 214.767.0432
TDD: 800.537.7697

To file a complaint online, go to:
https://ocrportal.hhs.gov/ocr/portal.lobby.jsf

For more information about privacy and your rights, go to:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html