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Notice of Privacy Practices

This notice describes how confidential information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully. I am required by law to maintain the privacy and security of your protected health information (PHI). I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. I must follow the duties and privacy practices described in this notice and provide you with a copy.

**You have a right to:**

**Receive an electronic or paper copy of your treatment record.**

Both law and the standards of my profession require that I keep appropriate therapy records. Your treatment records will be created and maintained in paper rather than electronic form. They serve to legally document your visit and typically contain information you provide to me regarding your personal contact information, emergency contact information, insurance information, if applicable, personal and health histories, session notes which serve as the basis for planning, assessing, and providing care to you in therapy as well as other documents, such as Releases of Information, limited billing and payment information, or documents you have provided or requested be sent to me by other care providers. Although your confidential records are the physical property of this practice, you are entitled to see or receive a copy of the records if you so choose. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Because these are professional records, they can be misinterpreted and/or can be upsetting to lay readers. I can prepare an appropriate summary, usually within 30 days, should you choose to request the treatment record. You will be charged an appropriate fee for any preparation time which is required to comply with an information request.

**Ask me to correct your treatment record.**

You can ask me to correct information about you in your treatment record that you think is incorrect or incomplete. Feel free to ask me more about this. I may decline your request, but I will inform you of the reason in writing within 60 days.

**Request confidential communications.**

You can ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address. I will agree to all reasonable requests.

**Ask me to limit what I use or share.**

You can ask me not to use or share certain health information for treatment, payment, or my practice operations. I am not required to agree to your request, and I may decline if it would affect your care. I will agree unless a law requires me to share that information with your health insurer. Should you choose to pay for services out-of-pocket, your insurer will not be engaged and your information will not be transmitted to them, unless required by law. I utilize a HIPAA compliant electronic billing service for claims filing and processing.

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**Receive a list of those with whom I have shared information.**

You can ask for a list (accounting) of the times I have shared your health information for six years prior to the date you ask, whom I have shared it with, and why. I will include all the disclosures except for those about treatment, payment, and practice operations, and certain other disclosures (such as any you asked me to make). I will provide one accounting per year at no cost to you but will charge a reasonable fee if you ask for another accounting within 12 months.

**Receive a copy of this privacy notice.**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. I will provide you with a paper copy promptly.

**Choose someone to act for you.**

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. I will make sure the person has this authority and can act for you before I take any action.

**File a complaint if you feel your rights are violated.**

If you feel I have violated your rights, you can complain by contacting me using my practice contact information listed at the beginning of this document. I encourage you to allow me the opportunity to discuss any complaint you might have with you in an effort to clarify any misunderstanding or resolve your concern. If you decide it necessary, you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting:

[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/). I will not retaliate against you for filing a complaint.

**You have both the right and choice to inform me if you wish for me to:**

Share information with your family, close friends, or others involved in your care. In the event of a disaster relief situation or if you were to become incapacitated while in session at my office, I would attempt to reach the person or persons via their contact information which you provide to me at intake. If I were unable to reach your contacts, I would take appropriate action and share only the information about you necessary to lessen a serious and imminent threat to safety.

**All information shared in the therapy sessions will remain confidential, as prescribed by law; however, there are a number of exceptions:**

**If** I believe there is a specific and realistic threat of danger to self or others. I am legally bound to take action to protect others from harm which may require my seeking hospitalization for the client who is threatening self-harm, or contacting a relative or others who can provide protection for him or her. In the case of the client threatening serious physical harm to another, I am required to take protective action which may include seeking hospitalization for the client or notification of the police and the intended victim. If such a situation should occur, I will make every effort to fully discuss it with you before taking action.

**If** I believe that child abuse or neglect to a minor still under the age of 18 may be occurring, or abuse or neglect of an elder or dependent adult.

**If** I am forced to defend myself in the event of litigation, formal complaint, or crime against me you have rendered.

**If** I am mandated through a written court order or administrative order to release confidentiality (which may include treatment notes), or in order to respond to a subpoena. In the event that you want to give written consent for me to share information with another party, a release of information form will be provided for this purpose. If it is of treatment benefit to you to disclose aspects of your confidential information to another party, such as a family member, spouse, or additional care provider, a Release of Information form will be provided for this purpose. Family therapy, couples therapy, or continuity of care circumstances involving a physician or other care provider are common instances in which others

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can be involved in the therapy, hence privy to confidential information, with the consent of the client. You will specify the name and contact information of the party or parties named therein, type and purpose of the disclosure, and the effective dates for which the Release of Information is to remain in effect. If the client is a minor, under the age of 18, the legal guardian(s) who has contracted for services has the right to receive confidential information regarding the child’s or adolescent’s treatment.

**If** you utilize a third party payor: Release of information is limited only to the necessary required information which may be requested from your record or regarding your progress in therapy by your insurer or its authorized agent for the purpose of determination of the need for treatment and/or services, determination of the need for continued services, or filing and settlement of the insurance claim.

Other circumstances do exist in which I am allowed or may be required to share your information. Your PHI can be disclosed in ways that the government deems beneficial to the public good. I have to meet many conditions in the law before I can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

**If** I am compelled by state or federal laws which require me to disclose information about you. The Department of Health and Human Services may request information regarding clients to determine privacy law compliance on my part.

**If** I am compelled for law enforcement purposes, I may release confidential information about you to a law enforcement official to investigate a crime or criminal act.

**If** I am forced to comply with special government functions which require me to disclose PHI, such as military, national security, and presidential protective services. I may also disclose your PHI to Workers’ Compensation and Disability programs or with health oversight agencies for activities authorized by law.

**Your PHI can also be shared for the following purposes:**

**Preventing** disease, product recalls, reporting of adverse reactions to medications, for use in health research, cooperation with organ procurement organizations, cooperation with a coroner, medical examiner, or funeral director when an individual dies.

**Breach** of Confidentiality:

**If** I become aware of a potential breach (improper acquisition, access, use, or disclosure) of your protected health information which compromises your security or privacy, I am legally required to perform a risk assessment, and then mitigate breaches and report them to you, the federal government, and, in some cases, the media.

**E-mail Communication:**

Contacting me via e-mail and txt can place the confidentiality of your communication at risk. If you find communication via e-mail or txt unavoidable, please be advised that I will only discuss appointment scheduling issues. My office telephone utilizes confidential voicemail for secure contact purposes.

Your confidential information will never be used for marketing, nor will it be shared for inclusion in a hospital directory, nor sold for any purpose.

I will not use or share your information other than as described herein unless you provide consent to me in writing. You may change your mind at any time with written notice.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

I reserve the right to change the terms of this notice, and the changes will apply to all information I have about you. The new notice will be available upon request, in my office, and on my web site.

Effective date of this notice: October 12, 2013

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