

**CCSN, Inc.**  
**HIPAA Notice of Privacy Practices**

**I. THIS NOTICE DESCRIBES HOW TREATMENT INFORMATION ABOUT YOU:**

**A. MAY BE USED AND DISCLOSED AND**

**B. HOW YOU CAN GET ACCESS TO THIS INFORMATION SHOULD YOU SO DESIRE.**

**PLEASE REVIEW IT CAREFULLY.**

**II. IT IS OUR LEGAL DUTY TO SAFEGUARD YOUR “PROTECTED HEALTH INFORMATION” (“PHI”).**

- A. By law we are required to insure that your PHI is kept private.
- B. The PHI constitutes information created or noted by us that can be used to identify you. It contains data about your past, present, or future health (including mental health) or condition, the provision of health care (including counseling) services to you, or the payment for such health care.
- C. We are required to provide you with this Notice about our privacy procedures. This Notice must explain when, why, and how we would use and/or disclose your PHI.
  - 1. Use of PHI means when we share, apply, utilize, examine, or analyze information within our practice;
  - 2. PHI is disclosed when we release, transfer, give, or otherwise reveal it to a third party outside our practice. With some exceptions, we may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, we are always legally required to follow the privacy practices described in this Notice.

Please note that we reserve the right to change the terms of this Notice and our privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with us. Should we make any significant changes to our policies, we will immediately change this Notice and post a new copy of it on our website, **ccsninc.com** and make it available from any of our counselors for your viewing. You may also request a copy of this Notice from us at any time.

**III. HOW WE WILL USE AND DISCLOSE YOUR PHI.**

We will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of our uses and disclosures, with some examples.

**A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations that Do Not Require Your Prior Written Consent. We may use and disclose your PHI without your consent for the following reasons:**

- 1. For treatment.** We can use your PHI within our practice (CCSN) to provide you with mental health treatment, including discussing or sharing your PHI with CCSN therapists, staff and supervisors, trainees and interns. Example: We may discuss your treatment with a supervisor or consult with another CCSN therapist in order to facilitate your care.
- 2. For health care operations.** We may disclose your PHI to facilitate the efficient and correct operation of our practice. Example: We may provide your PHI to our attorneys, accountants, consultants, and others to make sure that we are in compliance with applicable laws.

- 3. To obtain payment for treatment.** We may use and disclose your PHI to bill and collect payment for the treatment and services we provided you. Example: We might send your PHI to your insurance company or health plan in order to get payment for the health care services that we have provided to you. We could also provide your PHI to business associates, such as billing companies or collection companies.
- 4. Other disclosures.** Examples: Your consent isn't required if you need emergency treatment provided that we attempt to get your consent after treatment is rendered. In the event that we try to get your consent but you are unable to communicate with us (for example, if you are unconscious or in severe pain) but we think that you would consent to such treatment if you could, we may disclose your PHI.

**B. Certain Other Uses and Disclosures that Do Not Require Your Consent. We may use and/or disclose your PHI without your consent or authorization for the following reasons:**

- 1. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if we determine that disclosure is necessary to prevent the threatened danger.**
- 2. If disclosure is compelled or permitted by the fact that you tell us of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
- 3. If disclosure is mandated by the Mississippi Child Abuse and Neglect Reporting law.** For example, if we have a reasonable suspicion of child abuse or neglect.
- 4. If disclosure is mandated by the Mississippi Elder/Dependent Adult Abuse Reporting law.** For example, if we have a reasonable suspicion of elder abuse or dependent adult abuse.
- 5. To avoid harm.** We may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (e.g., adverse reaction to meds).
- 6. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: We may make a disclosure to the appropriate officials when a law requires us to report information to judicial court officials, government agencies, law enforcement personnel and/or in an administrative proceeding, of if disclosure is required by a lawful search warrant. (Mississippi law generally indicates that certain counseling information will not be disclosed in court proceedings, for example testimony by or written records of licensed Marriage and Family Therapists as they pertain to divorce-child-custody issues. However, in some instances courts may order the disclosure of such information.)
- 7. For health oversight activities.** Example: We may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
- 8. For specific government functions.** Examples: We may disclose PHI of military personnel and veterans under certain circumstances. Also, we may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
- 9. For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, we may need to give the county coroner information about you.
- 10. Appointment reminders and health related benefits or services.** Examples: We may use PHI to provide appointment reminders. We may use PHI to give you information about alternative treatment options, or other health care services or benefits we offer.
- 11. For Workers' Compensation purposes.** We may provide PHI in order to comply with Workers' Compensation laws.

**12. If an arbitrator or arbitration panel compels disclosure**, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

**13. If disclosure is otherwise specifically required by law.** Example: If compelled by U.S. Secretary of Health and Human Services to investigate or assess our compliance with HIPAA regulations, or compelled to comply with a lawful subpoena.

### **C. Other Uses and Disclosures of your PHI Require Your Prior Written Authorization.**

In any other situation not described in Sections IIIA and IIIB above, we will request and must obtain your written authorization before using or disclosing any of your PHI.

Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures of your PHI by us.

## **IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI**

These are your rights with respect to your PHI:

- A. The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. While we will consider your request, we are not legally bound to agree. If we do agree to your request, we will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that we are legally required or permitted to make.
- B. The Right to Amend Your PHI.** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that we correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of our receipt of your request. We may deny your request, in writing, if we find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of our records, or (d) written by someone other than us. Our denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and our denial be attached to any future disclosures of your PHI. If we approve your request, we will make the change(s) to your PHI. (We are not obligated to delete any information, only add corrections or additions.) Additionally, we will tell you that the changes have been made, and we will advise all others who need to know about the change(s) to your PHI.
- C. The Right to Get a List of the Disclosures We Have Made.** You are entitled to a list of disclosures of your PHI that we have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we give you will include disclosures made in the previous six years (if applicable) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no cost, unless you make more than one request in the same year, in which case we will charge you a reasonable sum based on a set fee for each additional request.
- D. The Right to See and Get Copies of Your PHI.** In general, you have the right to see your PHI that is in our possession, or to get copies of it; however, you must request it in writing. If we do not have your PHI, but we know who does, we will advise you how you can get it. You will receive a response from us within 30 days of our receiving your written request. Under certain circumstances, we may decide that we must deny your request, but if we do, we will give you, in writing, the reasons for the denial.

We will also explain your right to have our denial reviewed. If you ask for copies of your PHI, we will charge you not more than \$.50 per page. We may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

**E. The Right to Choose How We Send Your PHI to You.** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). We are obliged to agree to your request providing that we can give you the PHI, in the format you requested, without undue inconvenience. We may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

**F. The Right to Get This Notice by Email.** You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

## **V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**

If, in your opinion, we may have violated your privacy rights, or if you object to a decision we made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about our privacy practices, we will take no retaliatory action against you.

## **VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact the privacy officer at CCSN, listed below:

William J. Richardson, Ph.D.  
5422 Clinton Blvd.  
Jackson, MS 39209

## **VII. EFFECTIVE DATE OF THIS NOTICE**

This notice went into effect on November 12, 2008.

**CCSN, Inc.**  
**HIPAA Acknowledgement Form**

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

**I acknowledge that I have received a copy of the CCSN's HIPAA Notice of Privacy Practices.**

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**FOR OFFICE USE ONLY**

We have made every effort to obtain written **acknowledgement** of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (*Please provide specific details*) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**CCSN, Inc.**  
**Counseling Agreement and Indemnity Form**

I, \_\_\_\_\_, have applied for counseling services with CCSN, Inc. for myself and the following persons for whom I am a legal guardian: \_\_\_\_\_,  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_,  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_,  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.

I understand that CCSN offers counseling from a Christian perspective. I understand that services may be rendered by either a counselor/therapist licensed with the appropriate licensing board or a counselor/therapist with masters level training currently working towards licensure.

I also understand that audio recordings will be made of all counseling sessions. I give my consent to have these recordings made and to be used as clinical data for therapist training, staff meetings, as a part of therapy, review by supervisors and for educational and research purposes. This is with the understanding that in the event my case is used for educational or research purposes any personal information that may identify my case or that of the counselee will be appropriately omitted or disguised. In addition, I understand that all clinical information will remain strictly confidential among therapists, supervisors, and staff.

I further agree to indemnify and hold harmless CCSN, Inc. and its officers, directors, agents, servants and employees from any claims for damages of any nature arising out of, or allegedly due to, any counseling, instruction or advice rendered by personnel of CCSN, Inc. or out of any activity related thereto.

I understand that (1) CCSN is an independent counseling service, (2) CCSN is not the owner of the facilities in which my counseling services are to be provided, (3) CCSN counselors are not employees of the church or other third party owner of the facilities in which I obtain counseling services from CCSN, and (4) that counseling services provided by CCSN are not to be construed as services provided the church or other third party owner of the facilities in which I obtain counseling services from CCSN. I further agree to indemnify and hold harmless the church or other third party owner of the facilities in which I obtain counseling services from CCSN, as well as its elders, deacons, officers, directors, agents and employees, from any and all claims, damages, costs and expenses, including reasonable attorney's fees, arising out of my use of their facilities to obtain counseling services from CCSN or CCSN's provision of counseling services to me.

I have read the above information carefully, understand its contents, and agree to receive services for myself and/or my child under these conditions.

I understand that I may ask questions about any procedures or treatments offered to me at this clinic and that I may stop treatment at any time.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Counselor: \_\_\_\_\_