Kendall Ceban, LMHC, LLC

KendallCebanLMHC@gmail.com
923 Route 6A, Building 7
Yarmouth Port, MA 02675
774.205.1760

Notice of Privacy

Commitment to Confidentiality

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.

My Commitment

I respect your right to privacy. I will not disclose personally identifiable information about you without your permission, unless the disclosure is necessary to provide services to you or is otherwise in accordance with the law.

Collection of Information

I collect only *personal* or *medical* information I need to carry out treatment.

- Examples of *personal* information are name, address, date of birth, and social security number. Most often, you supply this information to get insurance authorization for session coverage.

- Examples of *medical* information are diagnoses, treatments, and names of providers who treat you. Most often, you supply this information during intake or treatment sessions.

Use and Disclosure of Information

I am required by law to protect the confidentiality of your personal and medical information and to notify you in case of a breach affecting your personal or medical information. I will supply your information to you upon our request or to help you understand treatment options and other benefits available to you.

I may also use and disclose your information without your written authorization for the following purposes, and as otherwise permitted or required by law:

- **Treatment**-to help providers manage or coordinate your health care and related services. For example, to refer you to another provider or remind you of appointments.

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- **Payment**-to obtain payment for your coverage and provide therapeutic services. For example, to initiate and manage authorizations, renew authorizations or coordinate coverage.
- **Health Care Operations**-to operate my business, including accreditation, credentialing, customer service, disease management, and fraud-prevention activities. For example, to do business planning, arrange chart reviews, and conduct quality assessment and improvement activities.
- **Legal Compliance**-to comply with the applicable law. For example, to respond to regulatory authorities responsible for oversight of government benefit programs or operations; to parties or courts in the course of judicial or administrative proceedings; to law enforcement officials during an investigations; or as necessary to comply with workers' compensation laws.
- **Research and Public Health**-for medical research studies in accordance with the laws for the protection of human research subjects, and to report to public health authorities and otherwise prevent or lessen a serious and imminent threat to health or safety. For example, for the purpose of preventing or controlling disease, injury, or disability.
- **To an Account (such as an HMO) or Party It Designates**-for administration of services under a health plan. For example, to a self-insured account for claim review and audits. I will disclose your information only to designated individuals. That, along with contract obligations, helps protect your information from unauthorized use.

To carry out the purposes, I share information with entities that perform functions for me subject to contracts that limit use and disclosure to intended purposes. I use physical, electronic, and procedural safeguards to protect your privacy. Even when allowed, uses and disclosures are limited to the minimum amount reasonably necessary for the intended task.

Special Notes Regarding Disclosure

Special protections apply to information about certain medical conditions. For example, with very few exceptions allowed by law, I will not disclose any information regarding HIV or AIDS to any party without your written permission. I reserve the right to provide a treatment summary as opposed to releasing your mental health records and only when a written request is made authorizing such disclosure with rationale for request.

Except as provided in this notice, I will not use or disclose your personal or medical information without your written authorization. A form for this purpose is available on request.

Specifically, I must have your written authorization to use or disclose your information for:

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- Use of PHI
- Clinical summary in lieu of use and disclosures of psychotherapy notes

You may revoke your authorization at any time. Your authorization must be in writing. Your revocation will not affect any action that I have already taken in reliance on your authorization.

Your Privacy Rights

You have the following rights with respect to your personal and medical information. To exercise any of these rights, contact me using the information listed at the end of this notice.

- **You have the right to receive information about privacy protections.** At intake you will be given a notice of your rights and may request a paper copy of this notice at any time.
- **You have the right to request a clinical summary at any time.** I will provide you with a summary of clinical information collected about you within 30 days of receiving a written request.
- **You have the right to receive an accounting of disclosures.** Your request must be in writing. My response will exclude any disclosures made in support of treatment, payment, and health care operations, or that you authorized (among others). An example of a disclosure that would be reported to you is a disclosure of your information in response to a subpoena from a judge.
- **You have the right to ask me to correct or amend information you believe to be incorrect.** Your request to correct, amend, or delete information should be in writing. I will notify you if I make an adjustment as a result of your request. If I do not make an adjustment, I will send you a letter explaining why within 30 days. In this case, you may ask me to make your request part of your records. I may also provide notice of your requested changes to others who received this information in the past two years.
- **You have the right to designate someone to receive information and interact with me on your behalf.** Your personal representative has the same rights concerning your information as you. Your designation and any subsequent revocation must be in writing, and must be accompanied by a completed health care proxy form.
- **You have the right to ask that I restrict or refuse to disclose personally identifiable information, and that I direct mail/telephone communications to you by an alternative means or to alternative locations.** While I may not always be able to agree, I will make reasonable efforts to accommodate requests. Your request and any subsequent revocation must be in writing.

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- **If you believe your privacy rights have been violated, you have the right to complain to me, using the standard grievance process, or to the Secretary of the U.S. Department of Health and Human Services, without fear of retaliation.**

About This Notice

This notice is effective May 3, 2021. I am required by law to provide this notice to you and to abide by it while it is in effect. I reserve the right to change this notice. Any changes will apply to all personal and medical information that I maintain, regardless of when it was created or received. Before I make any material changes in the privacy practice, I will post a new notice in my office. I will provide information about the changes to my privacy practices and how to obtain a new notice.

If you have any questions, please feel free to contact me at 774-205-1760 or the address listed at the top of this document.

ACKNOWLEDGEMENT RECEIPT: HIPAA NOTICE OF PRIVACY PRACTICES

In signing this form, you agree that you have received my **Notice of Privacy Practices**. This Notice, among other points, explains how I plan to use and disclose your protected health information for the purposes of treatment, payment and health care operations. This applies to the privacy practices of Kendall Ceban, LMHC, LLC and all affiliated covered entities issuing this Notice.

You have the right to review the **Notice of Privacy Practices** prior to signing this form. It provides more detail on how I may use and disclose your information. The **Notice of Privacy Practices** may change. A current copy may be requested by contacting me at 774-205-1760 or the address above.

By signing this form, you acknowledge you have received the **Notice of Privacy Practices** and that I can use and disclose your protected health information in accordance with HIPAA.

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Signature of individual or surrogate decision maker:

_____ _____

SIGNATURE & DATE PRINTED NAME