Kelly Knickerbocker, MSN, ARNP, PMHNP-BC, PLLC

NOTICE OF PRIVACY PRACTICES

The privacy of your health information is important to me. I will maintain the privacy of your health information and I will not disclose your information to others unless you tell me to do so, or unless the law authorizes or requires me to do so. A new federal law commonly known as HIPAA requires that I take additional steps to keep you informed about how I may use information that is gathered in order to provide health care services to you. As part of this process, I am required to provide you with the attached Notice of Privacy Practices and to request that you sign the attached written acknowledgement that you received a copy of the Notice. The Notice describes how I may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information I maintain about you and a brief description of how you may exercise these rights.

Professional Service Agreement

I would like to take this opportunity to welcome you to my practice and appreciate your confidence in choosing me as your mental healthcare provider. I am focused on providing you with the best quality care available and look forward to working together. Please view my website www.KellyKnickerbockerARNP.com in order to access or retrieve contact info or revised office protocols and/or disclosures. Visit www.healthgrades.com for testimonies.

Office Procedures I am in the office most days but typically seeing clients and often not available if you should call. You may leave a confidential voicemail at my OFFICE 425-954-3330. My office FAX is 425-249-3107. I make every effort to return non-emergent calls within 24-48 hours, excluding weekends and holidays. Any call lasting more than 5 minutes will be charged according to complexity. If you are a patient of record or receiving prescription medication from me please prioritize contacting your pharmacy to provide them with the most up-to-date office phone and office fax numbers listed and underlined above if you have not already done so as these were in effect 10/01/2023.

Confidentiality The quality healthcare you receive is strictly confidential. Information regarding your treatment will not be released without your written consent. However, there are exceptions to confidentiality as required by law; such as medical information or information regarding danger to yourself or others and neglect or abuse of a child.

Fees Consultations and treatment are on a fee-for-service basis. I am not in-network for your insurance company. You are welcome to utilize out-of-network mental health benefits and request an invoice from me for services paid for and rendered as a courtesy to submit to your insurance company. Please be aware that insurance company carriers do not reimburse for phone sessions or administrative service fees ranging from $50-$500 due prior to completion of forms, letters, record review, accommodations, etc.

Cancellations Forty-eight hour notice is required when canceling or rescheduling appointments. Monday appointments must be canceled prior to noon on Friday. A valid credit card number stored on file may be used in the event of a telephone session or missed appointment and must be placed on file before any appointment made to ensure no show fees are collected if appointments are missed or canceled with less than 48 hour notice. Appointments canceled without 48 hour notice will be charged to your credit card on file. Please note late cancellation fees are equivalent to charges for services anticipated at your appointment. If appointment time is reserved for more than 30-minutes, for example any extended time for additional psychotherapy or if you are coming in for an initial evaluation, you will be charged for the entire appointment. Your appointment begins at the stated time, not when you arrive and any appointment fifteen minutes or more into the start of appointment time will require rescheduling. Please note this may require more acute care I am unable to provide if you run out of medications between appointments or cannot be rescheduled right away. Follow-up appointments are not kept on schedule if missed appointments are unpaid.

Prescription Refills Prescriptions are refilled during your appointment and cannot be refilled early. For medication refills, please call your pharmacy several days before your current prescription expires and ask them to fax a refill request to 425-249-3107. If you have missed a scheduled appointment and need a medication refill, you will only be given enough medication until your next scheduled appointment and will be charged $25 for each approved prescription requiring refill. If your appointment is not rescheduled or you do not keep your appointment, you may experience medication withdrawal which may require treatment in the emergency department. Please know that medication refills cannot be authorized if recommended appointments are not kept. Therefore, it is important that you do not run out of medication before calling to refill a prescription. If you are a patient of record or receiving prescription medication from me please contact your pharmacy to provide them with the most up-to-date office phone and office fax numbers listed and underlined above if you have not already done so effective 10/01/2023.
After Hours In the event of a TRUE EMERGENCY please call 911 or visit your nearest hospital emergency room. In the event of a true crisis please call the 24-Hour Crisis Hotline at 866-4-CRISIS.

Acknowledgement
I have carefully read the information above and accept the Professional Services Agreement.

Signature: ____ Date: ________________________
I have also been given a copy of the office's Notice of Privacy Practices Act.

Signature: ____ Date: ________________________

Health Insurance Portability and Accountability Act (HIPAA)

This refers to a federal law that provides protection and patient rights with regards to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of Protected Health Information (PHI) for treatment, payment, and health care operations. The law requires that I obtain your signed signature acknowledging that I have provided you these disclosures at the end of this session. A description of the circumstances in which I may disclose information is provided for you. Please review it carefully so you understand fully what confidentiality does and does not mean in therapy. I am happy to discuss any of these rights with you.

<u>Notice of Privacy Practices</u>

With your signature on the Authorization form that I provide, I may disclose information in the following situations.

- Consultation with other health and mental health professionals
- Disclosures required by health insurers
- Disclosures required in collecting overdue fees. If your account has not been paid for more than 90 days and arrangements have not been agreed upon, I have the option of using legal means (small claims court) to secure payment. This requires me to disclose otherwise confidential information. If legal action is necessary, costs are included in the claim.
- Court Proceedings (discussed elsewhere in this Agreement)
- Government Agency requests for information in health oversight activities
- Patient-initiated complaint or lawsuit against me (I may disclose relevant information regarding that patient to defend myself).
- Patient-initiated worker's compensation claim and the services I am providing that are relevant to the injury for which the claim was made. I must, upon request, provide a copy of the patient's record to the patient's employer and the Department of Labor and Industries.
- If I have reasonable cause to believe a child has suffered abuse or neglect.
- If I have reasonable cause to believe that abandonment, abuse, financial exploitation or neglect of a vulnerable adult has occurred, the law requires that I file a report with the appropriate agency, usually the Department of Social and Health Services. Once such a report is filed, I may be required to provide additional information.
- If I reasonably believe there is imminent danger to the health or safety of the patient or any individual.

<u>Expanded Clinical Records Rights</u>

HIPAA provides you with several new or expanded rights with regards to your clinical records and disclosures of protected health information. These rights include:

- Requesting restrictions on what information from your clinical records is disclosed to others.
- Requesting an accounting of most disclosures of protected health information that you have neither consented or authorized.
- Determining the location to which protected information disclosures are sent.
- Having any complaints you make about my policies and procedures recorded in your records.
- The right to a paper copy of your signed Agreement, the attached Notice form, and my privacy policies and procedures.

<u>Communication by Mobile Phone and Email</u>

Based on the new HIPAA Guidelines I am including the information on the use of cell phones and emails for communication. Please know that I will take every precaution to be careful with my cell phone and

computer. However, it is important that you know the potential risks involved with confidentiality using these devices.

Mobile Phone Communication. Please note that if we communicate via my mobile phone by voice or text, your phone number will be stored in the phone's memory for a period of time and therefore if my mobile phone is lost or stolen, it is theoretically possible that your contact information might be accessed. Note that my mobile phone is password protected providing one line of defense against such a breach.

Email Communication. I do not communicate with patients via email. Please be aware that email is not completely confidential. All emails are retained in the logs of your and/or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be considered part of your treatment record. Please be aware that I regularly access email communications via my password-protected mobile phone. It is theoretically possible that if my mobile phone is lost or stolen and the password is somehow circumvented our email communications could be accessed.

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.

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I must follow the privacy practices that are described in this Notice (which may be amended from time to time). For more information about my privacy practices, or for additional copies of this Notice, please contact me using the information listed in Section II G of this notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures without Your Written Authorization

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. Treatment: I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling services to you. In addition, I may disclose PHI to other health care providers involved in your treatment.

2. Payment:All payments are due at the time of service.

3. Health Care Operations: I may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. Required or Permitted by Law: I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition

I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

5. Notification of Family and Others: Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.

B. Uses and Disclosures Requiring Your Written Authorization

1. Psychotherapy Notes: Notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization (this is not the same as medication notes).

2. Marketing Communications: I will not use your health information for marketing communications without your written authorization.

3. Other Uses and Disclosures: Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you (eg mental health, drug treatment or family planning services).

B. Right to Alternative Communications. You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions. You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. I am not required to agree to any such restriction you may request.

D. Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after October 1, 2023. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. Right to Request Amendment: You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time.

G. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact the Privacy Officer, Kelly Knickerbocker MSN ARNP PMHNP-BC PLLC 20216 Ballinger Way NE PMB 89 Shoreline, WA 98155. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the Director or myself.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on October 1, 2023.

B. Changes to this Notice. I may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in the waiting area of my office. You may also obtain any revised notice by contacting the Privacy Officer, Kelly Knickerbocker, MSN, ARNP, PMHNP-BC, PLLC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your signature below indicates that you have read the intake document and this agreement fully. It also serves as acknowledgement that you have received the HIPAA notice form. Once you have signed this page, your signature signifies that you understand your rights and responsibilities in therapy and it constitutes your agreement to the terms described in the intake document.
I have read the above policies on confidentiality, patient's rights, billing and insurance procedures and have had the opportunity to ask questions. I give permission for evaluation and treatment for myself (or my minor child).

By my signature below I, ____, acknowledge that I have

received a copy of the Notice of Privacy Practices for Kelly Knickerbocker, MSN, ARNP, PMHNP-BC, PLLC.

Signature of Client ____ Date __________________________

This form will be retained in your medical record. If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: ____

Relationship to Client: ____

For Office Use Only I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because * Individual refused to sign * Communications barriers prohibited obtaining the acknowledgement * An emergency situation prevented us from obtaining acknowledgement

* Other (please specify) ____