

**Christie Castner, LMFT**  
**Beaches Counseling & Therapy, LLC.**  
**2380 3<sup>rd</sup> Street South Suite# 2, Jacksonville Beach, FL 32250**  
**904.853.3300**

## **Notice of Privacy Practices**

I am required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information (PHI), and to provide you with a notice of my legal duties and privacy practices with respect to your PHI. This notice describes your legal rights, advises you of my privacy practices, and lets you know how Christie Castner, LMFT is permitted to use and disclose PHI about you.

This notice is covered under HIPAA (Health Insured Portability & Accountability Act). Any state law that is more stringent than the HIPAA rules and regulations has priority.

I am required to follow the privacy practices described in this Notice, though I reserve the right to change the privacy practices and the terms of this Notice at any time. If I do so, I will post a new Notice in the office waiting area.

## **How I May Use and Disclose Your Protected Mental Health Information**

I may use and disclose PHI for a variety of reasons. For most uses/disclosures, I must obtain your consent. However, the law provides that I am permitted to make some uses/disclosures without your consent. The following are some examples of potential uses/disclosures of your PHI.

### **1. For Treatment**

I may disclose your PHI to other mental health care practitioners who may be involved in providing your mental health care. For example, a referral to a mental health practitioner for additional assessment and/or long-term treatment would require a signed consent form from you to release and/or receive PHI about you to appropriately coordinate your care.

*(Exceptions: although your consent is usually required for the use/disclosure of your PHI for the activities described above, the law allows me to use/disclose your PHI without your consent in certain situations. For example, I may disclose your PHI if needed in emergency treatment if it is not reasonably possible to obtain your consent prior to the disclosure, and I think that you would give consent if able. Also, if I am required by law to provide your treatment, I may use/disclose your PHI for treatment without obtaining your prior consent.)*

### **2. For Payment**

I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due

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to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

**3. For Health Care Operations**

I may use or disclose as needed, your PHI in order to support my business activities, including but not limited to, quality assessment activities, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (i.e., answering services, billing and accounting services) provided I have a written contract with business that requires it to safeguard the privacy of your PHI.

**4. Required By Law**

Under the law, I must make disclosure of your PHI upon request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of litigating or determining my compliance with the requirements of the Privacy Rule.

**5. Without Authorization**

Applicable law and ethical standards permit me to disclose information about you and your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are:

Mandatory reporting of child or elder abuse or neglect

Required by Court Order

Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the treat, including the target of the threat.

**6. With Authorization**

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Please note that I take your treatment very seriously and honor and respect your privacy. Before any disclosures are made, I will always use my best professional judgment and will always take into consideration your best interest.

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**Notice of Privacy Practices**  
**Receipt and Acknowledgment of Notice**

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the "Notice of Privacy Practices: of Christie Castner, LMFT. I understand that if I have any questions regarding the Notice of my privacy rights, I can contact Christie Castner, LMFT.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Client Refuses to Acknowledge Receipt

\_\_\_\_\_  
Christie Castner, LMFT

\_\_\_\_\_  
Date