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C O M P A N Y

## HIPPA NOTICE of PRIVACY PRACTICES

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 PRIVACY COMMITMENT TO YOU:**

Your privacy is of the utmost importance. The information obtained by Sense of Hope Co. about you will be held to the highest levels of confidentiality. The law requires Sense of Hope Co. to give you a notice of the privacy practices and maintain the privacy of your confidential information. Unless you give written permission, information will only be disclosed when ethical and legal situations required the disclosure.

### **YOUR CONFIDENTIAL INFORMATION:**

I, Stephanie Voss, LMHP, PLADC, CPC, am a mental health care provider. More specifically, I am a Licensed Mental Health Therapist (LMPH), Provisionally Licensed Drug and Alcohol Counselor (PLADC), and Certified Professional Counselor (CPC) licensed by the State of Nebraska through the Nebraska Department of Health & Human Services - Regulation and Licensure. I create and maintain treatment records that contain individually identifiable health information about you. This notice applies to the information and records Sense of Hope Co. has about your psychotherapy, mental health status, substance use treatment and the care you receive at this office. This notice will tell you about the ways in which Sense of Hope Co. may use and disclose information about you and describes your rights and the obligations regarding the use and disclosure about that information.

### **MY DUTIES:**

I, Stephanie Voss, am required by law to maintain the privacy and confidentiality of your personal health information. This notice is intended to let you know of my legal duties, your rights, and my privacy practices with respect to such information. I am required to abide by the terms of the notice currently in effect. I reserve the right to change the terms of this notice and/or my privacy practices and to make the changes effective for all protected health information that I maintain, even if it was created or received prior to the effective date of the notice revision. If I make a revision to this notice, I will make the notice available at my office upon request on or after the effective date of the revision and I will post the revised notice in a clear and prominent location.

As the Privacy Officer of this practice (Sense of Hope), I have a duty to develop, implement and adopt clear privacy policies and procedures for my practice and I have done so. I am the individual who is responsible for assuring that these privacy policies and procedures are followed not only by me, but by any employees that work for me or that may work for me in the future. I have trained or will train any employees that may work for me so that they understand my privacy policies and procedures. In general, patient records, and information about patients, are treated as confidential in my practice and are released to no one without the written authorization of the patient, except as indicated in this notice or except as may be otherwise permitted by law. Patient records are kept secured so that they are not readily available to those who do not need them.

## WHAT IS “MEDICAL INFORMATION”:

The term “medical information” is synonymous with the terms “personal health information” and “protected health information” for purposes of this Notice. It essentially means any individually identifiable health information (either directly or indirectly identifiable), whether oral or recorded in any form or medium, that is created or received by a health care provider (me), health plan, or others **and** 2) relates to the past, present, or future physical or mental health or condition of an individual (you); the provision of health care (e.g., mental health) to an individual (you); or the past, present, or future payment for the provision of health care to an individual (you).

## PRACTICES AND USES:

Sense of Hope Co. may access, use and share medical information without your consent for purposes of:

- **Treatment:** We may use your medical information to provide you with mental health treatment, including discussing or sharing your medical information with trainees and interns. It may also be disclosed to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your medical information to your psychiatrist to coordinate your care in order to provide the best continuum of care.
- **Payment:** We may use and disclose your medical information so that the treatment and services you receive can be billed. For example, we may use your medical information from a therapy appointment in order to receive reimbursement for mental health services that have been provided to you.
- **Operations:** We may use and disclose medical information about you to operate Sense of Hope. For example, we may use medical information to review your treatment and services and to evaluate the performance of the health care professionals who provided services to you. I may also provide your medical information to my accountant, attorney, consultants or others to further my health care operations.
- **Patient Incapacitation or Emergency:** We may also disclose your medical information to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as an attempt is made to obtain your consent after treatment is rendered, or if an attempt is made to get your consent but you are unable to communicate (for example, if you are unconscious or in severe pain) and consent to such treatment appears to be a reasonable course of action if you were able to give consent.

**PLEASE NOTE:** I, or someone in my practice acting with my authority, may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your prior written authorization is not required for such contact.

## OTHER PERMITTED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT CONSENT/AUTHORIZATION:

- **Required By Law:** We may use or disclose your Protected Health Information (PHI) to the extent that the use or disclosure is required by law. You will be notified, if required by law, of any such uses or disclosures.
- **Public Health:** We may disclose your Protected Health Information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.
- **Communicable Diseases:** We may disclose your Protected Health Information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight:** We may disclose Protected Health Information to a health oversight agency for activities authorized by law, or other activities necessary for

appropriate oversight of the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

- **Abuse or Neglect:** We may disclose your Protected Health Information to a public health authority that is authorized by law to receive reports of abuse or neglect. The disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Legal Proceedings:** We may disclose Protected Health Information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.
- **Law Enforcement:** We may also disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.
- **Food and Drug Administration:** We may disclose your Protected Health Information as required by the Food and Drug Administration.
- **Research:** We may disclose your Protected Health Information to researchers when their research has been approved by an institutional review board to ensure the privacy of your Protected Health Information.
- **Criminal Activity:** We may disclose your Protected Health Information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Specialized Government Functions:** When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel for military, national security, and intelligence activities. Protected Health Information may be disclosed for the administration of public benefits purposes.
- **Workers' Compensation:** We may disclose your Protected Health Information as authorized to comply with workers' compensation laws and other similar legally established programs.
- **Inmates:** We may use or disclose your Protected Health Information if you are an inmate of a correctional facility in the course of providing care to you.
- **Required Uses and Disclosures:** We must make disclosures when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR, Title II, Section 164, et. seq.

**PLEASE NOTE:** The above list is not an exhaustive list, but informs you of most circumstances when disclosures without your written authorization may be made. Other uses and disclosures will generally (but not always) be made only with your written authorization, even though federal privacy regulations or state law may allow additional uses or disclosures without your written authorization. Uses or disclosures made with your written authorization will be limited in scope to the information specified in the authorization form, which must identify the information "in a specific and meaningful fashion." You may revoke your written authorization at any time, provided that the revocation is in writing and except to the extent that I have taken action in reliance on your written authorization. Your right to revoke an authorization is also limited if the authorization was obtained as a condition of obtaining insurance coverage for you. **If Nebraska law protects your confidentiality or privacy more than the federal "Privacy Rule" does, or if Nebraska law gives you greater rights than the federal rule does with respect to access to your records, I will abide by Nebraska law.** In general, uses or disclosures by me of your personal health information (without your authorization) will be limited to the minimum necessary to accomplish the intended purpose of the use or disclosure. Similarly, when I request your personal health information from another health care provider, health plan or health care clearinghouse, I will make an effort to limit the information requested to the minimum necessary to accomplish the intended purpose of the request. As mentioned above, in the section dealing with uses or disclosures for treatment purposes, the "minimum necessary" standard does not apply to disclosures to or requests by a health care provider for treatment purposes because health care providers need complete access to information in order to provide quality care.

#### USES AND DISCLOSURES REQUIRING AUTHORIZATION:

There are certain uses and disclosures of Protected Health Information that require your authorization. Among them are: most uses and disclosures of psychotherapy notes; uses and

disclosures of protected health information for marketing purposes; and disclosure of protected health information that constitutes a sale.

Other uses and disclosures not described in this notice will be made only WITH authorization from you. You may revoke this authorization at any time as provided by 45 CFR164.508(b)(5).

**YOUR RIGHTS TO PRIVACY:**

- **Right to Inspect and Copy.** You have the right to inspect and copy your medical information. Usually, this includes medical and billing records but does not include psychotherapy notes. To inspect and copy your medical information, you must submit a written request to Sense of Hope. If you request a copy, we may charge a fee for the cost of copying, mailing, and other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, you may request the denial be reviewed.
- **Right to Amend.** If you feel that medical information about you is incorrect or incomplete, you may ask us to amend (correct) the information. You have the right to request an amendment as long as the information is kept by or for Sense of Hope. To request an Amendment, your request must be made in writing and submitted to Sense of Hope, or to the privacy officer. In addition you must provide a reason, which supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for Sense of Hope;
  - Is not part of the information which you would be permitted to inspect and copy; or,
  - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request a list of the disclosures we made of medical information about you. You must submit your request in writing to Sense of Hope. Your request must state a time period for the disclosures, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list to be provided to you.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the mental health information we use or disclose about you for treatment, payment, health care operations, and to someone who is involved in your care or the payment of your care, like a family member or friend. We are not required to agree to your request for restrictions unless it is for payment or health care operations and you use your own funds to pay, in full, for a health care item or service. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to Sense of Hope. In your request you must tell us: (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about mental health matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing to Sense of Hope. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of this Notice.** You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, [www.senseofhope.org](http://www.senseofhope.org) or by contacting us.
- **Breach notification.** In the event Sense of Hope breaches your unsecured protected health information as defined by HIPAA, you will receive notification of the breach.

**PLEASE NOTE:** In order to avoid confusion or misunderstanding, I ask that if you wish to exercise any of the rights enumerated above, that you put your request in writing and deliver or send the writing to me. If you wish to learn more detailed information about any of the above rights, or their limitations, please let me know. I am willing to discuss any of these

matters with you. As mentioned elsewhere in this document, I am the Privacy Officer of this practice.

#### COMPLAINTS

For more information or if you believe your privacy rights have been violated you may file a complaint by simply providing in writing the specifics in which you believe the violation occurred, the approximate date of such occurrence, and any details that you believe will be helpful. This can be delivered to the Contact Person of this practice at: 12020 Shamrock Road, Suite 200, Omaha NE 68154 or filed with the Secretary of Health and Human Services at the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201. There will be no retaliation for filing a complaint.

#### CHANGES TO THE NOTICE OF INFORMATION PRACTICES

Sense of Hope reserves the right to amend this Notice at any time in the future. Until such amendment is made, Sense of Hope is required by law to abide by the terms of this Notice. Sense of Hope will provide notice of any material change in revision of these policies either electronically or in paper format.

#### CONTACT INFORMATION

This notice fulfills the "Notice" requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Privacy Rule. If you have questions about any part of this Notice of Information Privacy practices or desire to have further information concerning information practices at Sense of Hope please direct them to: HIPAA Privacy and Security Office, 301 Centennial Mall South 3<sup>rd</sup> Floor, Lincoln, NE 68509-5026, by phone at 402-471-8417, or by email to [DHHS.HIPAAOffice@nebraska.gov](mailto:DHHS.HIPAAOffice@nebraska.gov).

**If you need or desire further information related to this Notice or its contents, or if you have any questions about this Notice or its contents, please feel free to contact me. As the Contact Person for this practice, I will do my best to answer your questions and to provide you with additional information.**

This notice first became effective on May 2, 2018

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