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HIPPA INFORMATION FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). Additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov. You are advised of the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers and health insurance payers as is necessary and appropriate for your care. Patient files are stored in a locked file cabinet. You agree to the normal procedures utilized within my office for the handling of charts, patient records, PHI and other documents or information.
2. Communication between therapist and patient may occur by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. It is your right to inform me how you wish to receive information and to limit what I disclose, except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. The practice of psychotherapy may utilize a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to my attention in written form.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. You will have access to your records in accordance with state and federal laws. I may deny your access to PHI under certain circumstances, but you may have this decision reviewed.
8. I may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within my office concerning your PHI. However, I am not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.