KRISTA H. SAND, LICSW, LADC-I | 13 Bowdoin Street Suite 1A/B | Boston, MA 02114 | 603.988.6486

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I am required by a federal law, the Health Insurance Portability and Accountability Act (HIPAA), to make sure that your protected health information (PHI) is kept private. HIPAA also requires me to inform you of my privacy practices in writing. Federal law requires me to document that you received this notice. Please sign below so that this signed copy can be put in your record. Another copy is provided to you for your records.

PHI is information that alone, or in conjunction with other data that is collected from or about you, would allow you to be identified. This includes demographic information collected from you that relates to your past, present and future physical or mental health condition, the provision of health care to you, or payment for that care. This information (PHI), which goes into your record, includes information such as but not limited to, your history, the reasons you came to see me for treatment, a diagnosis or diagnoses, a treatment plan, progress notes, notes from telephone messages, emails you send me and that I send you, other written correspondence by you, records I get from others who have treated you, information about medications you take or have taken, physical conditions, testing you have done or diagnostic treatment purposes, legal information and billing and insurance information.

In order to provide treatment and collect payment for services, your PHI is used and disclosed in a number of different ways. For example, I use this information to plan your care and treatment, to discuss your treatment with other healthcare professionals who are treating you or to the professional who referred you to me, for billing purposes to your health insurance company, and for quality assurance purposes. There are a number of additional ways that the law permits your PHI to be used without your authorization. A detailed list of these additional means will be provided to you upon request or can be found by looking up information on line about HIPAA.

By signing this document, I acknowledge that I have received a copy of the Privacy Practices of Krista H. Sand, LICSW, LADC-I.

_____

Client Name (Please Print)

_____

Client Signature

_____

Parent, Guardian or Legal Representative Signature
(if minor or needed otherwise)

_____

Date