GROWTH AND HEALING
WELLNESS CENTER, LLC

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed. Please review it carefully and sign to acknowledge you understand the HIPPA Privacy Practices listed below.

The Health Insurance Portability and Accountability Act of 1996, (HIPAA), effective April 14, 2003, mandates that health care providers inform individuals of their rights with regard to Protected Health Information, (PHI) (information that is personally identifiable; your name, address, phone number, social security number, etc.). To this end we have listed below the individuals who have access to your PHI and the circumstances in which we would use or disclose your PHI:

Growth and Healing Wellness Center, LLC will use and disclose PHI for the following reasons:

1. With consent from the Client or Parent, should the client be a minor.
2. Where legal regulations explicitly demand disclosure without the client's consent. Client is a danger to self or others, in the case of known or suspected child abuse or neglect, we may inform law enforcement officials, (i.e., Police, Sheriffs Dept., Department of Children and Family) and when ordered to by a court order, court ordered subpoena, administrative tribunal, (social security admin).
3. With your consent we will share information to coordinate your care with your primary care physician, if necessary or any other health practitioner, teacher, etc. that needs to be involved in treatment coordination.
4. At your request, we will send service information and diagnosis to your insurance company for claims payment. We will also abide by Quality Assurance practices of the insurance company, if we send in claims to them.
5. At your request we will send information regarding your services to your attorney or other selected individual.
6. In the case of a mandatory employee assistance referral we will, with your consent, send compliance information to the appropriate person at work.

____________________________________	_______________
Signature of Client	Date
____________________________________	_______________
Signature of Spouse, Significant Other, or Parent	Date
____________________________________	_______________
Signature of another client in Family Counseling	Date
____________________________________	_______________
Signature of another client in Family Counseling	Date