Healing Hearts Ranch, Inc.

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HIPPA Notice of Privacy and Security 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information about you. Including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your clinician, and our office staff and others outside of our offices that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes if the coordination or management of your health care is with a third party. For example, we would disclose your protected health information, to a home health or service agency that provides care to you. Additionally, your protected health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Emergency: We are mandated reporters by the state of Kansas statutes and must report all incidents suspected to the Department of Children and Families as required by Kansas reporting law (K.S.A. 38-2223).

This information may be disclosed without consent to the client and/or guardian as deemed by the law and other safety factors.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for specific therapy sessions to be reimbursed, relevant protected health information may be disclosed to the health plan to obtain approval for admission and treatment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, employee review activities, mult-disciplinary team meetings with other professionals and agencies, training of equine specialists and/or clinicians, licensing and conducting or arraignment for other business activities. For example, we may disclose your protected health information to a counselor in training who is completing their practicum/clinical supervision at our locations. In addition, we may say your name as you leave or enter the facility as another is leaving. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

**Other Permitted and Required Uses and Disclosures:** These will only be made with your consent, authorization or opportunity to object unless required by law.

*You may revoke this authorization at any time, in writing, except to the extent that your clinician or clinician’s practice has taken action in reliance on the use or disclosure indicated in the authorization.*

**Your Rights:**

Following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If you request a copy of the information, we may charge you a fee for the costs of copying, mailing and other supplies and services associated with your requests. We may require that you pay for such a fee prior to receiving the requested copies. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notifications purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.

Your clinician is not required to agree with your request. If your clinician believes it is in your best interest to permit use or disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You must complete a form providing information we need to process your request.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from this practice. Upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your clinician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This is a list of disclosures we may make of health information about you, with certain exceptions specifically defined by law. To request this accounting of disclosures you must complete a specific form providing the information we need to process your request. To obtain this form or obtain more information concerning this process, please contact the clinician or receptionist. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Breach notification:** you have the right to be notified if your protected health information is breached, unless it is determined through our risk-assessment review that the impermissible use or discloser posed is not significant risk of “financial, reputational, or other harm” to you. Our privacy officer is Jennifer Hosman, who can be reached at programdirector@hhrts.net or 620-792-5173.

**Complaints:**  You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. *You will not be penalized for filing a complaint.*

This notice was published and becomes effective on/or before April 13, 2003 and was updated 12/29/17.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at 620-792-5173.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_