Healing Pathways, PLLC
7310 N Alpine Road
Loves Park, IL 61111

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED & HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR RESPONSIBILITES

- Healing Pathways, PLLC is required by state and federal laws to maintain the privacy and security of your protected health information.
- Healing Pathways, PLLC will promptly inform you if a breach occurs that may have compromised the privacy and security of your protected health information.
- Healing Pathways, PLLC will not use or share your protected health information other than as described in this notice. We will only release information about you in accordance with federal and state laws, in addition to the counseling profession's ethics.
- Healing Pathways, PLLC must follow the privacy practices outlined in this notice and provide you with a copy.

USES & DISCLOSURES FOR WHICH YOUR AUTHORIZATION IS NOT REQUIRED

- ***Treatment:*** Healing Pathways, PLLC can use or disclose your health information to provide, manage, and coordinate your care. This may include consultants, referral sources, or other professionals involved in your treatment.
- ***Healthcare Operations:*** Healing Pathways, PLLC can use or disclose your health information to train staff, as well as review our treatment and business procedures. It may also be utilized for certification, compliance, and licensing activities.
- ***Payment:*** Healing Pathways, PLLC can use or disclose your health information to verify insurance coverage and benefits, in addition to process claims. It may also be utilized for billing and collections purposes.
- ***Public Health & Safety:*** Healing Pathways, PLLC can use or disclose your health information to report adverse reactions to medications and assist with disease prevention. It may also be utilized to prevent/reduce a serious threat to anyone's health or safety, which could include making a report to the appropriate state or local agencies.
- ***Abuse or Neglect:*** Healing Pathways, PLLC can disclose your health information to report suspected abuse, neglect, or domestic violence to the appropriate state or local agencies. The information disclosed is limited to what is necessary to make the initial report.
- ***Medical Emergencies:*** Healing Pathways, PLLC can use or disclose your health information in a medical emergency solely to the medical personnel involved.
- ***Required by Law:*** Healing Pathways, PLLC can use or disclose your health information if state or federal laws require it, including the Department of Health & Human Services to ensure we are complying with federal privacy laws.
- ***Deceased Patients:*** Healing Pathways, PLLC can disclose your health information to a coroner, medical examiner, or funeral director.
- ***Respond to Legal Actions:*** Healing Pathways, PLLC can use or disclose your health information in response to a court order or subpoena.
- ***Workers' Compensation:*** Healing Pathways, PLLC can use or disclose your health information for worker's compensation claims.

- ***Law Enforcement & Government Requests:*** Healing Pathways, PLLC can use or disclose your health information for law enforcement purposes. It may also be utilized for special government functions or health oversight agencies.

YOUR RIGHTS

- ***Obtain Records:*** You have the right to inspect and obtain a copy of your medical record.
- ***Amend Records:*** You have the right to ask about adding information or amending your medical record if you feel it is inaccurate or incomplete. A decision will be made within 60 days and, under certain circumstances, your request may be denied.
- ***Request an Accounting of Disclosures:*** You have the right to request an accounting of disclosures. This excludes disclosures made about treatment, payment, and healthcare operations. This also excludes information required to be released by law and information you gave specific consent to be released. This request is not to exceed six years.
- ***Ask for Limits on what is Used or Shared:*** You have the right to ask for restrictions on the uses and disclosures of your health information, however, we are not required to agree to your request especially if it would affect your care. If services are fully paid for out-of-pocket you have the right to ask that information not be shared with your health insurer. This request will be granted unless disclosures are required by law.
- ***Request Confidential Communications:*** You have the right to ask to be contacted in a specific manner. For example, you can request that mail be sent to a different address or a specified telephone number be utilized.
- ***Choose Someone to Act for You:*** If you have a legal guardian or medical power of attorney that individual can exercise your rights and make choices about your health information. We will ensure the person has this authority prior to taking any action.
- ***Receive a Copy:*** You have the right to receive a copy of this privacy notice at any time.
- ***File a Complaint:*** You have the right to file a complaint if you believe your privacy rights have been violated. Please contact Healing Pathways, PLLC directly to discuss any concerns. If you are not satisfied with the outcome, you may submit a written complaint to the U.S. Department of Health & Human Services by mailing a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling 1-877-696-6775. Healing Pathways, PLLC will not retaliate against you for any complaints filed.

THIS NOTICE WILL GO INTO EFFECT FEBRUARY 1, 2022. THE TERMS OF THIS NOTICE CAN BE CHANGED AT ANY TIME & A NEW DOCUMENT WILL BE AVAILABLE UPON REQUEST.

PATIENT'S ACKNOWLEDGEMENT & CONFIRMATION OF RECEIPT

Healing Pathways, PLLC gave me a copy of their Notice of Privacy Practices which was explained and discussed. It was made known I may ask questions at any time and I consent to these policies being part of my mental health treatment.

_____ Date: _____/_____/_____

Signature of Patient (If minor 12-17 yrs.)

_____ Date: _____/_____/_____

Signature of Parent/Legal Guardian/Power of Attorney

_____ Date: _____/_____/_____

Signature of Witness