NANCY WETHERELL, LPC, NCC, PLLC
Independent Licensed Therapist

HIPPA NOTICE OF PRIVACY PRACTICES

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

Effective date: June 10, 2010

Nancy Wetherell, LPC, NCC, PLLC has been and will always be totally committed to maintaining client's confidentiality. I will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes my policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow me to use and disclose your health information for these purposes.

TREATMENT. I may need to use or disclose health information about you to provide, manage or coordinate your care or related services. This could include consultants and potential referral sources.

PAYMENT. Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. I may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS. I may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

OTHER USES OR DISCLOSURES OF YOUR INFORMATION WHICH DOES NOT REQUIRE YOUR CONSENT. There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Arizona State Law, I am obligated to report this to Child Protective Services. If you provide information that informs me that you are in danger of harming yourself or others. Information to remind you of /or to reschedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Acknowledgement of Receipt of Privacy Practices

By signing below, you indicate that you have read, understand, consent, agree to the contents of this document. By signing this document, you are agreeing to begin treatment.

Client _____ _____
Print Name \ Signature Date

Legal Guardian _____ _____
Print Name \ Signature Date

Witness _____ _____
Nancy Wetherell, LPC, NCC, PLLC \Signature Date

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