This notice outlines your protected health information (PHI), how it may be used, and what your rights are. Please review carefully and ask any questions you have, prior to signing it. Please direct all questions to **Purple Health Wellness*,*** contact@purplehealthwellness.com.

We, **Purple Health Wellness**, understand that PHI about you and your health is very personal. We are committed to protecting your PHI. This notice applies to ALL of the records of your care/coaching generated by **Purple Health Wellness** and our personnel. This notice will explain the ways in which we could use and disclose PHI about you. We also describe your rights and certain obligations we have regarding the use and disclosure of PHI. The law requires us to:

 \*make sure that your PHI that identifies you is kept private

 \*notify you about how we protect your PHI

 \*explain how, when, & why we use and disclose PHI

 \*follow the terms of the notice that is currently in effect

We are required to follow the procedures in this notice. We reserve the right to change the terms of this notice and to make new notice provisions effective for all PHI that we maintain by:

 \*providing copies of this notice upon registration as a client of **Purple Health Wellness.**

 \*providing copies of this notice upon request

 \*posting a copy of this notice on our Facebook page or website.

How we may use and disclose protected health information about you:

The following categories describe different ways that we use and disclose PHI without your written authorization.

For TREATMENT & Continuity of Care: We may use PHI about you to provide you with, coordinate, or manage your medical or health treatments or associated services. We may disclose PHI about you to health care providers, or other health care team members that are involved in providing your health care. **Purple Health Wellness** may also share PHI in order to coordinate the different parts of your treatment plan you need, such as pharmaceuticals, lab work, and x-rays; this provision of care may also extend to providers outside **Purple Health Wellness** staff as it relates to your health care and continuity of such care.

For PAYMENT: **Purple Health Wellness** may disclose certain health information to others for billing, invoicing, and/or receiving payment for services you receive from **Purple Health Wellness**. Only the minimal information required by such third parties will be disclosed.

As required by Law: **Purple Health Wellness** may disclose your health information as required by law as in cases pursuant to legal authority, to report information as related to victims of abuse, neglect or domestic violence, and/or to assist law enforcement officials in standard law enforcement duties.

For Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury or disability or for other health oversight activities.

 **Your Written Authorization is REQUIRED for other uses & disclosures**

Including:

 Uses & disclosures for PHI for marketing purposes; and

 Disclosures that constitute a sale of your PHI.

Your PHI Rights:

 You have the right:

* to request restrictions to certain uses & disclosures of your PHI; however, (INSERT LLC NAME HERE) may not be required to agree to such requested restrictions.
* Obtain a paper copy of this Notice of Privacy Practices upon request
* Inspect and obtain a copy of your health record as provided for under the law
* Amend your health record, according to law, by submitting a written request
* Request communications of your PHI by alternative means, (i.e. email, fax, etc)
* Receive an accounting of disclosures made of your PHI
* Request an electronic copy of your record be provided to you.

**CLIENT RIGHTS AND Provider DUTIES**

**Use and Disclosure of Protected Health Information:**

* ***For Treatment* –** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
* ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
* ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

**Patient's Rights:**

* ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
* ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
* ***Right to Request Restrictions*** *–* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
* ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** *–* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
* ***Right to Inspect and Copy*** *–* You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
* ***Right to Amend*** *–* If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
* ***Right to a Copy of This Notice*** *–* If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
* ***Right to an Accounting*** *–* You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
* ***Right to Choose Someone to Act for You*** *–* If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
* ***Right to Choose*** *–* You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
* ***Right to Terminate*** *–* You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
* ***Right to Release Information with Written Consent*** *–* With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

**Provider’s Duties:**

* I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

Obligations of **Purple Health Wellness**:

**Purple Health Wellness** is required by law to:

* Maintain the privacy of PHI and notify you in the event of a breach, if the breach poses significant risk to you
* Provide you with THIS notice of our legal duties & privacy practices with respect to your PHI
* Abide by the terms of this notice
* Notify you if we are unable to agree to a requested restriction on how your information is used
* Accommodate reasonable requests you make to communicate PHI by alternative means
* Obtain your written consent to use or disclose your PHI for any reason other than listed herein

*Complaints & Information*

You may submit any written complaints regarding potential breaches in privacy or requests for further information by contacting **Purple Health Wellness*,*** contact@purplehealthwellness.com.

**Purple Health Wellness** reserves the right to change its information practices & to make new provisions effective for all PHI that we maintain. Revised notices will be made available on our Facebook page and/or website.

***By typing or signing my FULL name below, I acknowledge that I have received and read a copy of this Privacy Notice from (*Purple Health Wellness*).***

Sign\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT full name BELOW:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO VIDEO CHAT**

By signing below, I hereby consent to the use of a video chat for my medical visit via a video conference call. Due to the President’s Emergency Declaration, I understand the media, link, or software used for this video visit may not be fully HIPAA compliant. I understand that **Purple Health Wellness, Trisha Antoine** will take all appropriate and available actions to help keep these visits safe and secure. I release **Purple Health Wellness, Trisha Antoine**, from any and all liability and responsibility associated with any possible and accidental release of personal health information.

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***INFORMED CONSENT***

By signing below, I hereby consent to health care management and treatment by **Trisha Antoine, Purple Health Wellness**. I acknowledge that it is my responsibility as a patient to seek out information needed regarding my diagnosis, management, treatment plan, and medications. I agree to be a partner in my health care and in decisions related to my care.

***Signature*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_