

HIPAA Acknowledgment

I understand that I have specific rights to privacy regarding my protected health information. (Protected health information refers to information that is related to past, present, and future information about your physical and mental health.)

I understand that this information can be used to

- Obtain payment from insurance companies and other third-party payers, including secure electronic billing.
- Conduct, plan, and direct my treatment among healthcare providers who may be involved directly or indirectly in my treatment.
- Perform normal operations such as quality of care assessments and provider certifications.

I understand that it is the clinician's obligation to contact Child Protective Services (CPS) if an individual discloses abuse, neglect, or risk to a child or vulnerable adult.

I received a copy (electronic or paper) of the privacy policy and was given the opportunity to review this policy before signing this acknowledgment.

I understand that Reflections Counseling has the right to make changes the privacy practices. I have the right to contact Reflections Counseling at any time to obtain the most current copy of the privacy policy.

I understand that I may request certain restrictions related to how my protected health information is used or disclosed for treatment or payment. This request must be made to Reflections Counseling in writing. I further understand that Reflections Counseling is not required to comply with my request.

Printed Name of Client

Signature of Client or Parent/Legal Guardian

Date