PO Box 763
280 Main Street, Suite 14
Hill City, SD 57745
Office: 605.390.8791

403 National Street, Ste 1
Rapid City, SD 57702
Office: 605.390.8791

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.

Our commitment to your privacy

As part of providing professional care to you, we will do all we can to maintain the privacy of what is called your "protected health information" (PHI). We are also required by law to keep your PHI private. These laws are complicated, and we must give you this important information. This page is a shorter description of what we do to maintain your privacy. If you would like to read the more detailed version, please ask any staff member for a copy.

How we use and disclose your protected health information (PHI) with your consent

We will use the information we collect about you mainly to provide you with treatment; to arrange payment for our services; and for some other business activities called, in the law, "health care operations." We will ask you to sign a separate consent form to show that you understand these ways we handle your information. If you do not agree and won't sign this consent form, we will not treat you. If we want to use or send, share, or release your PHI for other purposes, we will discuss this with you so you fully understand it, and ask you to sign a release-of-information form to allow this.

Disclosing your health information without your consent

There are sometimes when the laws require us to share your information without getting your consent. They are described in the longer version of our Notice of Privacy Practices, but here are the most common situations:

1. When there is a serious threat to your or another person's health or safety or to the public. We will only share information with people who are able to help prevent or reduce the danger.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. When a law enforcement official requires us to do so.
4. For workers' compensation and some similar programs if you seek these benefits.

Your rights about your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, rather than at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical chart, case file, and billing records. You can get a copy of these records, and we can charge you for it.
4. If you believe that the information in our records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation.
5. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with Suzette Wasvick Counseling Services and with the South Dakota Board

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of Counselor Examiners. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

6. You have the right to a copy of this notice.

Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. Suzette Wasvick Counseling Services staff will be happy to discuss these situations or answer any questions now or as they arise. The effective date of this notice is 6/1/2020.

Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____ and Suzette Wasvick Counseling Services. When we use the words "you" and "your" below, this can mean you, your child, or a person for whom you are the legal or personal representative if you have written his or her name here:_____.

When we examine, evaluate, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide what treatment is best for you and to provide this treatment to you. We may also share this information with others to arrange payment for your treatment, to help others provide other treatment to you, or to carry out certain business or government functions.

By signing this form, you are agreeing to let us use your PHI here and to send it to others for the purposes described just above. Your signature below acknowledges that you have read or heard our Notice of Privacy Practices, which explains in more detail what your rights are and how we can use and share your information. If you do not sign this form agreeing to our privacy practices, we cannot treat you, because we need to use your PHI to evaluate, diagnose, and treat you.

In the future, we may change how we use and share your PHI, and so we may change our Notice of Privacy Practices. If we do change it, you can get a copy from Suzette Wasvick Counseling Services staff.

After you have signed this consent, you have the right to revoke it in writing. We will then stop using or sharing your PHI, but if we have already used or shared some of it, and we cannot change that.

Signature:_____ Date:_____

Printed: _____

Signature: Suzette Wasvick Counseling: Suzette Wasvick