Aspire Services Group, LLC
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Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed, and how you can access your information. Please review it carefully.

Commitment to Your Privacy

The privacy and protection of your health information is as important to me as it is to you. I am dedicated to maintaining the privacy or your health information. In providing you with healthcare, I create records about the treatment and services that are provided to you. I am required by the Health Insurance Portability and Accountability Act (HIPAA) to protect and maintain the confidentiality of health information that is maintained by my practice. In accordance with HIPAA, my practice has developed written policies regarding the use and disclosure of your health information. As a client of this office, you are entitled to receive notice about my privacy practices and how I may use and disclose your health information in different circumstances. This notice explains how I may use and disclose your health information, the rights you have about how your health information is disclosed, and my obligation to protect the privacy of your health information.

Introduction. When you become a client of this office, you provide me with information about your health. Each time you visit, a record of your visit is created. Your health record is the information that I use to plan your care, provide treatment, and receive payment for my services. It is important for you to understand that your health record contains personal health information that is protected by federal and state laws.

My Responsibility. My office is required to maintain the privacy of your personal health information and to provide you with a notice about legal duties and privacy practices with respect to your health information. I am also required to accommodate reasonable requests that you make to communicate personal health information by alternative means or alternative locations. Any time I use or disclose your personal health information, I must follow the terms of this Notice.

Uses and Disclosures for Treatment, Payment, and Healthcare Operations

After providing you with this Notice, I may use your health information to provide treatment, to obtain payment for your treatment, and for my internal health care operations. I may use and disclose your personal health information in the following situations:

1. For Treatment. I may use and disclose your personal health information to obtain payment for healthcare services I have provided you.
2. For Payment. I may use and disclose your personal health information to obtain payment for healthcare services I have provided to you.
3. For Healthcare Options. I may use or disclose your protected health information for my healthcare options. For example, to perform risk assessments and other administrative tasks to monitor the quality of care that I provide.

To Request Confidentiality in Certain Communications. You have the right to request to receive written health information by alternative means of communication or at alternative locations. For instance, you may request that I contact you at home rather than at work.

To File a Complaint. If you believe that your privacy rights have been violated, in addition to filing a complaint with me, you have the right to file a written complaint with the Office of Civil Rights of the United States Department of Health and Human Services. Upon request, the Privacy Officer will provide you information needed to file the complaint. Under no circumstances will I, the Privacy Officer, retaliate against you for filing a complaint with me, or the Office of Civil rights.

Changes to Notice. I reserve the right to change my privacy practices and to alter this Notice according to those changes. In the event that this Notice changes, I will provide you with a revised Notice at the next session or mail you the revised Notice to the address I have on file.

By signing this Notice, I understand that I have had the opportunity to ask Dr. Benavidez any questions or concerns I may have about this Notice. I agree to the above statements in this Notice.

____________________________________ _______________________

Printed Client Name Date

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Signature of Client

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Micaela Benavidez, Psy.D., LP Date