

**CENTER FOR WELLBEING**

**Chandana Becker, PhD, MTI, RPP, SEP**

**1835 E. Mission Blvd. P.O. Box 3698 Fayetteville, AR 72702**

**phone: 479-442-2026 fax: 479-442-2897 email: cbeckerphd@sbcglobal.net**

**Notice of Privacy Practices - Short Version**

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

My commitment to your privacy

My practice is dedicated to maintaining the privacy of your personal health information. I am required also by law to do this. These laws are complicated, but I must provide you with important information. This is a short version of the full, legally required Notice of Privacy Practices, NPP which you received along with this so refer to it for more information. However, I can not cover all possible situations so please talk to me about any questions or problems you may have.

I will use the information about your health which I get from you or from others mainly to provide you with treatment, to arrange payment for my services or for some other business activities which are called, in the law, health care operations. After you have read this NPP I will ask you to sign a Consent Form to let me use and share your information. If you do not consent and sign this form I cannot treat you.

If I or you want to use or disclose (send, share, release) your information for any other purposes will discuss this with you and ask you to sign an Authorization to allow this.

Of course I will keep your health information private but there are some times when the laws require me to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization who is able to help prevent or reduce such threat of harm.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires me to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations which do not happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask me to call you at home, and not at work to schedule or cancel an appointment. I will try my best to do as you ask.
2. You have the right to ask me to limit what I tell certain individuals involved in your care or the payment for your care, such as family members and friends. While I do not have to agree to your request, if I do agree, I will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information I have about you such as your medical and billing records. You can get a copy of these records but I may charge you for copies. Contact me if you want to arrange this.

4. If you believe the information in your records is incorrect or incomplete, you can ask me to make some kinds of changes (amendments) to your health information. You have to make this request in writing and send it to me as the Privacy Officer. You must tell me the reasons you want to make the changes.

5. You have the right to a copy of this notice. If I change this NPP I will post it in our waiting room and you can always get a copy of the NPP from me as Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me as Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact me as Privacy Officer by phone at 479-442-2026 or by email [cbeckerphd@aol.com](mailto:cbeckerphd@aol.com)  
The effective date of this notice is April 14, 2003

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**CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION**

This form is an agreement between you, \_\_\_\_\_  
and me, Chandana Becker.

When I use the word "you" below, it will mean your child, relative, or other person if you have  
written his or her name here \_\_\_\_\_

When I interview, evaluate, diagnose, treat, or refer you I will be collecting what the law calls  
Protected Health Information (PHI) about you. I need to use this information here to decide on  
what treatment is best for you and to provide treatment to you. I may also share this  
Intonation with others who provide treatment to you or need it to arrange payment for your  
treatment or for other business or government operations.

By signing this form you are agreeing to let me use your information here and to send it to  
others. The Notice of Privacy Practices, NPP explains in more detail your rights and how I can  
use and sham your information. Please read the NPP before you sign this Consent form.

**If you do not sign this consent form agreeing to what is in my Notice of Privacy Practices  
I cannot treat you.**

In the future I may change how I use and share your information and so may change my  
Notice of Privacy Practices. If I do change it, you can get a copy by calling me.

If you are concerned about some of your health information, you have the right to ask me to  
not use or share some of it for treatment, payment, or administrative purposes. You will have to  
tell me what you want in writing. Although I will try to respect your wishes, I am not required to  
agree to these limitations. However, If we do agree, I promise to comply with your wishes.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me  
you no longer consent) and I will comply with your wishes about using or sharing your  
information from that time on but I may already have used or shared some of your information  
and cannot change that

\_\_\_\_\_  
Signature of client or his or her personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client or personal representative

\_\_\_\_\_  
Relationship to the client

\_\_\_\_\_  
Description of personal representative's authority

Date of NPP \_\_\_\_\_

Copy given to the client/parent/personal representative.