MOSAIC
INFUSIONS & WELLNESS

Privacy Practices and Policies Acknowledgment and Authorization

This Privacy Practices and Policies Acknowledgment and Authorization ("Acknowledgment and Authorization") describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

1. Uses and Disclosures for Treatment and Health Care Operations
    A. I may use or disclose your Protected Health Information ("PHI") for treatment purposes with your consent.
        a. To help clarify these terms, here are some definitions:
            i. "PHI" refers to information in your health record that could identify you.
            ii. "Treatment" is when I provide, coordinate or manage your health care and other services.
            iii. "Use" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
            iv. Disclosure applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

2. Uses and Disclosures Requiring Authorization
    A. I may use or disclose PHI for purpose outside of treatment when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes I have made about our conversation during a private, group, joint or family counseling session. These notes are given a greater degree of protection than PHI.
    B. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that I have relied on that authorization.
    C. By signing this Acknowledge and Authorization, I acknowledge and give my authorization to Release PHI within Mosaic Infusions & Wellness. If I am receiving treatment from two or more providers within Mosaic Infusions & Wellness, I give my permission for my providers to coordinate my treatment.

D. By signing this Acknowledgment and Authorization, I acknowledge and give my authorization to Release PHI to financial institutions which request documentation regarding services rendered.

3. Uses and disclosures with Neither Consent nor Authorization

A. I may use or disclose PHI without your consent or authorization in the following circumstances:

a. Child Abuse: If I have reasonable cause, on the basis of my professional judgment, to suspect abuse of children with whom I come into contact in my professional capacity, I am required by law to report this to the DHS.

b. Adult and Domestic Abuse: If I have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), I may report such to the local agency which provides protective services.

c. Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made about the professional services I provided to you or the records thereof, such information is privileged under state law, and I will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance in such case.

d. Serious threat to Health or Safety: If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and I determine that you are likely to carry out the threat, I must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent or notifying applicable federal and/or state authorities.

4. Patient's Rights and Therapist's Duties 1.

A. Patient's Rights:

a. 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.

b. Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – you have the right to request and receive confidential communication of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me. Upon your request, I will send communications to another address or phone number.

c. Right to Inspect and Copy – You have the right to inspect or obtain a copy of PHI in my mental health record for as long as the PHI is maintained in the record. However, I reserve the right to deny your access to PHI under certain

circumstances. On your request, I will discuss with you the details of the request and denial process.

d. Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. However, I reserve the right to deny your request. Upon your request, I will discuss with you the details of the amendment process.
e. Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice) At your request, I will discuss with you the details of the accounting process.

B. Therapist's Rights:
   a. 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.
   b. I reserve the right to change the privacy policies and practices described in this Acknowledgment and Authorization. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
   c. If I revise my policies and procedures, I will provide you with a revised notice by mail or in person.

5. Complaints
   A. If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please bring this to my attention.
6. Effective Date, Restrictions and Changes to Privacy Policy

   A. This Acknowledgment and Authorization will take effect June 1, 2022.

I acknowledge that I have received, read and fully understand the office policies and consents of Mosaic Infusions & Wellness and I hereby authorize and agree to these terms in order to receive psychiatric/psychotherapy treatment by him or one of his associates. Adam O'Neill & Associates, LLC a Virginia company DBA Mosaic Infusions & Wellness.

_____
Patient Name

_____ _____
Patient Signature Date