

WACHS-MILLER THERAPY SERVICES

Michael Miller, LPC | License #PC017705 | NPI 1629816798
Virtual Therapy Services | Pennsylvania
michael@wachsmillertherapy.com | (215) 436-9060 | wachsmillertherapy.com

NOTICE OF PRIVACY PRACTICES

Effective Date: November 1, 2026

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 DUTIES

Wachs-Miller Therapy Services LLC ("the practice," "we") is required by law to maintain the privacy and security of your protected health information (PHI), to give you this Notice of our legal duties and privacy practices, to follow the terms of the Notice currently in effect, and to notify you promptly if a breach occurs that may have compromised the privacy or security of your information.

HOW WE MAY USE AND DISCLOSE YOUR INFORMATION

Treatment. We use your information to provide mental health services. We will share it with other providers involved in your care only with your written authorization, except in an emergency or as otherwise permitted by law.

Payment. We use and disclose information to bill and collect payment, including submitting claims to your health plan through Headway, our billing and credentialing partner, when you use insurance.

Health care operations. We use information to run the practice, for example for quality review, licensing, and legal and regulatory compliance.

Business associates. We work with vendors that handle information on our behalf, such as SimplePractice (electronic records, telehealth and client portal) and Headway (insurance billing). They are required by written agreement to protect your information.

Appointment reminders. We may contact you with appointment reminders and information about your care, using the contact methods you have authorized.

DISCLOSURES WITHOUT YOUR AUTHORIZATION

We may use or disclose information without your written authorization only when required or permitted by law, including:

- To prevent or lessen a serious and imminent threat to the health or safety of you or others;
- To report suspected abuse or neglect of a child, older adult, or person with a disability, as required by Pennsylvania law;
- In response to a court order. Under Pennsylvania law, a subpoena alone is generally not sufficient to release mental health records;
- To health oversight agencies, such as a professional licensing board, for activities authorized by law;
- To public health authorities, coroners or medical examiners, for workers' compensation, or for specialized government functions, as required by law.

USES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

We will not use or disclose the following without your written authorization: **psychotherapy notes** (except in limited situations allowed by law); your information for **marketing** purposes; or any **sale** of your information. Other uses and disclosures not described in this Notice will be made only with your written authorization. You may revoke an authorization in writing at any time, except to the extent we have already acted on it.

ADDITIONAL PROTECTIONS

Pennsylvania law. Pennsylvania provides additional confidentiality protections for mental health treatment records. When state law is more protective of your privacy than federal law, we follow the more protective law. This often means we need your written consent before sharing information even when HIPAA alone would permit the disclosure.

Substance use disorder records. If we receive records protected by federal confidentiality rules for substance use disorder treatment (42 CFR Part 2), those records, or testimony about their content, will not be used or disclosed in any civil, administrative, criminal, or legislative proceeding against you without your written consent or a court order accompanied by a subpoena, after notice and an opportunity to be heard as required by law.

YOUR RIGHTS

- **Inspect and get a copy** of your records, including an electronic copy. Requests must be made in writing. We may charge a reasonable, cost-based fee. Access may be limited in rare circumstances allowed by law, and you may request review of a denial.
- **Request an amendment** if you believe information is incorrect or incomplete. We may deny the request in writing and explain why.
- **Receive an accounting** of certain disclosures made in the past six years, other than for treatment, payment, health care operations, and disclosures you authorized.
- **Request restrictions** on how we use or share your information. We are not required to agree, except that **we must agree** not to share information with your health plan about a service you paid for in full out of pocket, unless the law requires the disclosure.
- **Request confidential communications**, such as contacting you at a different phone number or address. We will agree to reasonable requests.
- **Choose someone to act for you**, such as a legal guardian or someone with medical power of attorney.
- **Be notified of a breach** of your unsecured health information.
- **Get a paper copy** of this Notice at any time, even if you agreed to receive it electronically.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the practice using the contact information below, or with the U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Avenue S.W., Washington, D.C. 20201, 1-877-696-6775, or www.hhs.gov/ocr/privacy/hipaa/complaints/. **We will not retaliate against you for filing a complaint.**

CHANGES TO THIS NOTICE

We may change the terms of this Notice, and the changes will apply to all information we have about you. The current Notice is available on our website at wachsmillertherapy.com and upon request.

CONTACT

Michael Miller, LPC — Privacy Officer

Phone: (215) 436-9060 | Email: michael@wachsmillertherapy.com | Website: wachsmillertherapy.com

ACKNOWLEDGMENT OF RECEIPT

By signing below, I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices for Wachs-Miller Therapy Services LLC.

Client signature _____ Date _____

Client printed name _____