Nexus Relational Therapy LLC
Nolan Billstrom, MFT-IT
Madison Psychotherapy and Wellness
3001 W Beltline Hwy Suite 402
Madison, WI 53713

Notice of Privacy Practices

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form) or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. Limits of Confidentiality

There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by my own choice and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.
I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

- **Emergency:** If you are involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.
- **Child Abuse and Neglect Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by Wisconsin law to report the matter immediately to the appropriate social service organization, including law enforcement as appropriate.
- **Adult Abuse Reporting:** In Wisconsin, reporting the suspected abuse of an elderly or incapacitated adult, including abuse, neglect, or exploitation, is discretionary for the professional. I always err on the side of making a report. By working with me, you understand that I will likely report abuse of elderly or incapacitated adults to the Wisconsin Department of Health Services.
- **Payment:** We may use or disclose health information about you so that the treatment services you receive may be billed to, and payment may be collected from you, an insurance company, or another third-party payer. For example, we may provide portions of your health information, such as your name, diagnosis, and the specific treatment that you are receiving, to our billing department and your health plan to get paid for services provided to you. In certain situations, we may disclose your health information to a collection agency if a bill is not paid.
- **Health Oversight:** Wisconsin law does not require that licensed psychologists, social workers, and counselors report misconduct by a health care provider of their own profession. However, professionals are granted civil immunity in good faith reporting to a licensing board when a licensee of that board is practicing in an unethical or dangerous manner. By policy, I also reserve the right to report misconduct by health care providers of other professions. If you describe unprofessional conduct by another mental health provider of any profession, I will discuss with you how to make such a report. If you are a health care provider, I may be required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. The Wisconsin Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.

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- **Court Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court. In Wisconsin civil court cases, therapy information is not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, Wisconsin has no statute granting therapist-patient privilege that I am aware of, although records can sometimes be protected on another basis. Protections of privilege may not apply if I do an evaluation for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.
- **Imminent Threat to Health or Safety:** Under Wisconsin law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or a law enforcement officer, whether you are a minor or an adult.
- **Workers Compensation:** If you file a workers' compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.
- **Records of Minors:** Wisconsin has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child's records; and CSB evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child. Other circumstances may also apply, and we will discuss these in detail if I provide services to minors.

Except as described in this Notice, I will not use or disclose your health information without your written authorization. For example, your authorization is required for most uses and disclosures of health information for marketing purposes and any other collateral contacts. Your authorization is required for most uses and disclosures of psychotherapy notes, which are notes recorded by a mental health provider documenting or analyzing the contents of conversations with you during counseling sessions that are kept separate from the rest of your health information. If you authorize us to use or disclose your health information, you may revoke that authorization, in writing, at any time to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization). If you wish to withdraw your authorization, I ask that you do so by writing the request and sending it to my office.

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III. Patient's Rights and Provider's Duties:

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure, or both; and 3) to whom you want the limits to apply.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications 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 your bills to another address. You may also request that I contact you only at work, or that I do not leave voicemail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.
- **Right to an Accounting of Disclosures:** 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). On your written request, I will discuss with you the details of the accounting process.
- **Right to Inspect and Copy:** In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for the costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative proceeding.
- **Right to Amend:** If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing and submitted to me. In addition, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.
- **Right to a copy of this notice:** You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you, as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.
- **Notified of a Breach:** We are required by law to maintain the privacy of protected health information and you have the right to be notified if your unsecured protected health information has been the subject of a breach.
- **Complaints:** If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services

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EFFECTIVE DATE: 6/9/2025

Contact Information:
If you have any questions or concerns regarding your privacy rights or the information in this Notice, please contact me directly at **nexusrelationaltherapy@gmail.com** or **(608) 509-9364.**

Acknowledgement of Receipt of Privacy Notice.
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.