Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read and review carefully.

This notice is effective April 1, 2003 and will remain in place until we replace it.

1. **Our pledge regarding medical records**- The privacy of your medical information is important to us We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our practice. We need this record to provide you with quality care and to comply with certain legal requirements.. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of your medical information.
2. **Our Legal Duty**-

   Law requires us to:

   1. Keep your medical information private.
   2. Give you notice describing our legal duties, privacy practices and your rights regarding your medical information
   3. Follow the terms of the notice that is now in effect.

   We have the right to:

   1. Change our privacy practices and the terms of this notice at any time, provided that law permits the changes.
   2. Make the changes in our privacy practice and the new terms of our notice effective for all medical information that we keep including information preciously created or received before this change.

   Use and disclosure of your medical record

   The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed, however, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any reason not isted below without your specific written permission. Any specific written authorization may be revoked by writing to us at anytime.

   For treatment:

   We may use medical information to provide you with medical treatment or services. We may disclose medical information about you to other doctors, nurses, technicians, medical students or other healthcare professionals to help in further treatment of your medical condition(s). We may also disclose medical information to obtain authorization from your insurance company for treatments and /or services.

   For Payment:

   We may use and disclose your medical information to our billing office and your insurance company to obtain payment for services rendered.

   For Healthcare Operations:

   We may use and disclose your medical information for the purpose of our personal healthcare operations.

Patient Rights

You have the right to:

- Express concerns about any aspect of your care without fear of retaliation, and/or utilize the office's own grievance procedures.
- File a complaint with HIPPA
- Request and receive copies of your medical information and billing information
- Receive considerate and respectful care

- Receive timely and competent care
- Verbal and physical privacy as much as is reasonably possible
- Request a person of your own sex be present during a medical exam
- Expect that our medical information will be protected and accessed by only those people who are directly involved in your case.
- Expect reasonable safety and security while in the office
- To ask questions
- Receive clear and prompt answers to your healthcare questions.
- The right to refuse any and all treatments

Patient Responsibilities

- To provide accurate and complete medical information about your health
- To participate in your care and in decision making
- To report any changes in your condition
- Ask questions when you do not understand information given to you
- Follow your doctor's orders and instructions
- Keep appointments, be on time and have the courtesy to call when unable to do so.
- Review your living will or Durable Power of Attorney and make sure there is a copy on file with all your healthcare providers.
- Be considerate of the needs and privacy of other patients
- Provide insurance information and pay your bill promptly

ACKNOWLEDGEMENT

Patient Rights and Privacy Practices

I have received the Notice of Privacy Practices and a copy of the Patient Rights and have been provided an opportunity to review it.

I understand that if I refuse to sign this the office has the right to refuse services.

Name ___________________________________

Birthdate_________________________________

Signature________________________________Date_______________