

Notice of Privacy Practices

As Required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

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.

A. Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- ❖ You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. This can be done by visiting our release of information service provider, HealthMark Group at <https://requestmanager.healthmark-group.com/register>.
- ❖ We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- ❖ You can ask us, in writing, to correct health information you believe is incorrect or incomplete.
- ❖ We may say “no” to your request, but if we do, we’ll tell you why in writing within 60 days.

Request confidential communications

- ❖ You can ask us, in writing to contact you in a specific way.
Examples: Alternate telephone number or address, email, asking us to refrain from leaving messages on answering machines or from mailing information to you.
- ❖ We will say “yes” to all reasonable requests.
Example of unreasonable requests: Those that would be too difficult technologically or practically for the practice to accommodate.

Ask us to limit what we use or share

- ❖ You can ask us, in writing not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if we believe it would affect your care.
- ❖ If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- ❖ You can ask for a list (accounting), in writing of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- ❖ We will include all the disclosures outside of those related to treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Examples of disclosures outside the scope of treatment, payment, and health care operations: A list of times we shared your Protected Health Information (PHI) with family or friends (as directed from your authorization form.)

Get a copy of this privacy notice

You can ask for a paper or electronic copy of this notice at any time, and we will provide you with it promptly. It can be requested via encrypted email, fax, mail, in person or through HealthMark Group electronically.

Choose someone to act for you

- ❖ If you have appointed someone as your Legal Representative or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- ❖ We will ask to see the certified copy of the order of appointment.

File a complaint if you feel your rights are violated

- ❖ You can complain if you feel we have violated your rights by contacting us at

Patient Services Manager: Mikaela Champagne

Email: patientservices@dfwra.com

- ❖ You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- ❖ We will not retaliate against you for filing a complaint.

B. Your Choices

For certain health information, you can tell us your choices. If you have a clear preference for how we share your information, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to designate who we can share your information with.

Example: Family, close friends, or others involved in your care.

In these cases, we never share your information unless you give us written permission:

- ❖ Marketing purposes
- ❖ Sale of your information

C. Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other medical professionals related to your care.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Example: Appointment reminders

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services

How else can we use or share your health information?

We are allowed or required to share your information in other ways such as:

- ❖ **Public health and safety issues**
- ❖ **Research**
- ❖ **Compliance with the law**
- ❖ **Inmates**
- ❖ **Respond to organ and tissue donation requests**
- ❖ **Work with a medical examiner or funeral director**
- ❖ **Address law enforcement and other government requests including Military and Veteran Authorities**
- ❖ **Respond to court orders including subpoenas or other legal actions**

Our Responsibilities

- ❖ We are required by law to maintain the privacy and security of your protected health information.
- ❖ We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- ❖ We must follow the duties and privacy practices described in this notice and give you a copy of it.
- ❖ We will not use or share your information other than as described here unless you tell us we can in writing.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site at www.dfwra.com.

Patient & Guarantor Responsibilities Insurance Disclaimer

I (name of patient/guarantor) _____ understand that if my insurance does not pay for my office visit or any other services performed for any reason, I remain fully responsible to pay for all services provided. It is the patient/guarantor's responsibility to understand how their insurance coverage works.

Initial here: _____

___ It is the patient/guarantor's responsibility to determine if their provider/practice is IN or OUT of network with their insurance by calling their insurance company. Patient/guarantor is still responsible to pay for all services rendered even if the provider/practice is OUT of network or services are non-covered.

___ It is the patient/guarantor's responsibility to update our office every time their insurance coverage changes, lapses, or terminates prior to any services rendered.

___ The Patient/Guarantor understands that private pay fees or any fees separate from insurance are subject to change without notice.

By signing below, I hereby acknowledge that I have read, understood, and agree to all the above Patient/Guarantor responsibilities, Insurance Disclaimer & Private Pay policies of Rheumatology Associates.

Patient Signature: _____

Date: _____