Wallace Physical Therapy Notice of Privacy Practices

To Our Patient: This notice describes how health information about you (as patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulation created as a result of the Health Insurance Portability and Accountability Act Of 1996(HIPAA).

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realized that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your health information
- Your privacy rights
- Our obligations concerning the use and disclosure of your health information

We may use and disclose your health information in the following ways

The following categories describe the different ways in which we may use and disclose your health information.

1. Treatment: Physicians and staff may use or disclose your health information in order to treat you or assist others in your treatment. Additionally, we may disclose your health information to others who may assist in your care, such as your spouse, children or parents.
2. Payment: Our practice may use your health information to bill and collect payment for the services you receive from us. We may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for your treatment. We also may use or disclose this information to obtain payment from third parties that may be responsible for such costs, such as family members. Also we may use your health information to bill you directly for services and items.
3. Health Care Operation: We may need to use and disclose your health information to be able to run our practice at the highest clinical standards and effectively as possible. This could be used to evaluate the performance of our physicians and staff, to determine if our treatment plans are effective, or determine if there are other services we should be offering,. We may also compare our clinical data with other practices; review it with medical students, medical faculty, technicians, and other for teaching and learning purpose. We will strive to remove information that identifies you from this medical information.
4. Disclosures required by law. Our practice will use and disclose your health information when we are required to do so by federal, state and local law.
5. Appointment Reminders and Sign Sheet: We may want to call you by phone for appointment reminder purposes. Please advise us if you by phone for appointment reminder message at your home, possible on your answering machine, or with any co-worker at your place of work. We may also use a “Sign-In” sheet at front desk, for purpose of logging our patient as they arrive.

Use and disclosure of your health information in certain special circumstances

The following circumstance may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court administrative order.
3. If asked to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosure to person organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials. If you are an inmate or under the custody of a law enforcement official.
8. For workers Compensation and similar programs.

Your rights regarding your health information:

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain locations. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care of the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our Privacy Officer.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Privacy Officer.
5. Right to a copy of this notice. You are entitled to receive a copy this notice of privacy practices. You May ask us to give you a copy of this notice at anytime. To obtain a copy of this notice, contact our Privacy Officer.
6. Right to file a compliant. If you believe that your privacy rights have been violated, you may file a compliant with our practices Privacy Officer, or with the

Secretary of Department of Health and Human Services. All complaints must be submitted in writing, ad you will not be penalized for filing a compliant.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain written permission from you to disclose information in ways that have been identified in this notice, or are not permitted by these laws. **CONTACT OUR PRIVACY OFFICER IF YOU HAVE ANY QUESTIONS.**

WITH THIS SIGNATURE, I ACKNOWLEDGE THAT I HAVE BEEN GIVEN A COPY OF THE PRIVACY NOTICE FOR THIS PRACTICE

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SIGNATURE PRINT NAME DATE

WALLACE PHYSICAL THERAPY DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations. I understand that the identity of the requesting designated party(s) must be verified before the release of any information.

Authorized Designees:

NAME: ______________________RELATIONSHIP__________________

NAME: ______________________RELATIONSHIP__________________

NAME: ______________________RELATIONSHIP__________________

NAME: ______________________RELATIONSHIP__________________

PATIENT NAME: ____

PATIENT SIGNATURE: ____

DATE: _________________________

Wallace Physical Therapy will only release information over the phone to those listed above. Provided they are able to give a correct birth date for the patient and are able to confirm the password designated by the patient.

Please list here the password that you will give to the designated parties listed below.

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