NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AN HOW YOU CAN GET ACCESS TO THIS INFORMATION . PLEASE REVIEW IT CAREFULLY.

Introduction:

At our office, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices (HIPPA) describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they are related to your protected information. This notice is effective August 1, 2013 and applies to all protected health information as defined by Federal regulations.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:

Each time you visit our office a record of your visit is made. Typically this record contains your symptoms examination, and test results, progress and psychotherapy notes, diagnosis and treatment plans for future care and treatment. This information, often referred to as your health or medical record, serves as a:

- basis or planning your care and treatment,
- means of communication among the many health care professionals who may contribute to your care,
- legal documentation describing the care you received,
- means by which you or a third party payer can verify that services billed were actually provided,
- a tool in educating health professionals
- a source of information for public health officials charged with improving the health of this state and the nation,
- a source of data for our planning and marketing; ie. business planning such as staffing and marketing such as business promotions,
- a tool with which we can access and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record nd how your health information is used helps you to ensure its accuracy, better understand who, what, when, where and why others may access your health informtion, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of our office and specifically your physician, the information belongs to you. You have the right to:

- obtain a paper copy of this notice of information practices on request,
- inspect and copy your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communicatons of your health record by alternative means or alternative locations

- request a restriction on certain uses and disclosures of your health information s provided in 45 CR 164.522
- revoke your authorization to use or disclose heath information except to the extent that action has already been taken
- request that your health information not be released to your insurance carrier if you agree to be financially responsible.

OUR RESPONSIBILITIES:

Our office is required to:

- maintain the privacy of your health informtion,
- provide you with this notice as to our legal and privacy policies with respect to information we collect and maintain about you
- abide by terms of this notice
- notify you if we are unable to agree to a requested restriction
- accomodate reasonable requests you may have to communicate health information by alternative means or alternative locations, this includes hard copy and electronic media.

We reserve the right to change our practices and to make the new provisions effective for all protected health informtion we maintain. Should our information change, we will make these new policies available to you either in the office or by mail to the address you provide or if you agree, we will email the revised notice to you.

We will NOT use or disclose health information WITHOUT YOUR AUTHORIZATION, except as described in this notice. We will also discontinue to use or disclose your health information after we receive a written revocation of the authorizing to the procedures included in the authorization.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions and would lke additional information, you may contact your doctor or the office manager at 770-801-0980.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U S Department of Health and Human Services. There will be no retaliation for filing a complaint with either our physician or the Office of Civil Rights. The OCR address is: Office of Civil Rights, U S Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS:

For treatment: Information obtained by your physician will be recorded in your record and used to determine the course of treatment that should work best for you. This may include diagnosis, preliminary treatment plan, as well as subsequent observations, and changes in diagnosis or treatment plans. This information may be obtained based on direct observations, statements made directly by you, or from collateral sources such as family members or other caregivers or other practitioners. This document provides for the most accurate possible information with which to guide and evaluate your

care.

For payments: When filing for benefits with an insurance carrier or third party payer, information such as your name, identification information, diagnosis, and appropriate service codes may be required to process the claim.

Other health care operations: We may use your information to access the care and outcomes in your case and others like it. This information will then be used in an effort to improve the quality of and effectiveness of the healthcare and services we provide.

Business associates: In the event you are referred to a specialist for addtional treatment, you patient information along with appropriate diagnosis, laboratory results, certain tests, and progress notes will be shared with the referral so that the new physician can perform the job we have asked them to do. We do require that they protect your information to the same extent as we would.

Notification: We may disclose information to notify a family member, personal representative, or other person responsible for your care, your location, or general condition as necessary and appropriate.

Communication with family: We may disclose to a family member or other person named by you, information relevant to the person's involvement in your care.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health care related benefits and services that might be of interest to you.

FDA: We may disclose to the FDA health information relative to advere events with respect to food, supplements, medications, or other products to enable recalls, repairs or replacements.

Workers Compensation: We may disclose health information to the extent authorized by law when necessary to comply with laws relating to Workers Compensation or other similiar programs.

Public health: As required by law, we may release information to public health or legal authorities charged with preventing or controlling disease, injury, or disablity.

Law enforcement: We may disclose health information for law enforcement purposes as required by law to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health agency, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more of our patients, workers or public.

I understand that my physician, as part of my treatment, maintains paper and/or electronic health records. I understand I have been provided a Notice of Information of Health Information Privacy Policies which provides a complete description of information uses and disclosures. I understand my rights and priveleges as described therein.

I understand that as part of treatment, payment or health care operations, it may be necessary to release my protected health information to another entity and I consent to such disclosure for these permitted purposes including disclosure by electronic media such as fax and/or email.

I understand the office has the right to change these polices in accordance with Section 64.520 of the Federal Regulations and may do so so long as I am provided with a copy of the new policies.

I understand the office is not required to agree to restrictions I may make.

I understand should I refuse to sign this consent or should I revoke this consent, the office may refuse to treat me as permitted by Section 164.506 of the Federal Regulations.

I fully understand and accept the terms of this consent. _____

I decline the terms of this consent. _____

Patient signature: _____ Date: _____