HIPAA

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 REVIEW IT CAREFULLY.**

Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to:

- Maintain the privacy of medical information provided to us
- Provide notice of our legal duties and privacy practices
- Abide by the terms of our Notice of Privacy Practices currently

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address, and phone number
- Information relating to your medical history
- Your insurance information and coverage
- Information concerning your doctor, nurse or other medical providers

In addition, we will gather certain medical information about you and will create a record of the care provided to you. Other individuals or organizations that are part of your "circle of care"- such as the referring physician, your other doctors, your health plan, and close friends or family members also may provide some information to us.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

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

Required Disclosures. We are required to disclose health information about you to the Secretary of Health and Human Services, upon request, to determine our compliance with HIPAA and to you, in accordance with your right to access and right to receive an accounting of disclosures, as described below.

For Treatment. We may use health information about you in your treatment. For example, we may use your medical history, such as the presence or absence of a disease to determine if you are a good candidate for surgery.

For Payment. We may use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give payer information about your current medical condition so that it will pay for services rendered. We may also need to inform your payer of the treatment you are going to receive in order to obtain prior approval or to determine whether the service is covered.

For Health Care Operations. We may use and disclose information about you for the general operation of our business. For example, we sometimes arrange for auditors or other consultants to review our practices, evaluate our operations, and tell us how to improve our services. Or, for example, we may use and disclose your health information to review the quality of services provided to you.

Our Business Associates. We sometimes work with outside individuals and businesses that help us operate our business successfully. We may disclose your health information to these business associates so that they can perform the tasks that we hire them to do. Our business associates must promise that they will respect the confidentiality of your personal and identifiable health information.

Disclosures to Persons Assisting in Your Care or Payment for Your Care. We may disclose information to individuals involved in your care or in the payment for your care. This includes people and organizations that are part of your "circle of care" -- such as your spouse, your other doctors, or an aide who may be providing services to you. We may also use and disclose health information about a patient for disaster relief efforts and to notify persons responsible for a patient's care about a patient's location, general condition or death. Generally, we will obtain your verbal agreement before using or disclosing health information in this way. However, under certain circumstances, such as in an emergency situation, we may make these uses and disclosures without your agreement.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment or that you should schedule an appointment.

Treatment Alternatives. We may use and disclose your personal health information in order to tell you about or recommend possible treatment options, alternatives or health-related services that may be of interest to you.

Public Policy Uses and Disclosures. We may disclose health information about you when we are required to do so by federal, state, or local law.

- To public health authorities and health oversight agencies that are authorized by law to collect information
- Lawsuits and similar proceedings in response to a court or administrative order
- If required to do so by law enforcement
- 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 disclosures to a person or organization able to help prevent the threat.
- If you are a member of U.S. or foreign military forces (including veterans) and if required by appropriate authorities
- To federal office for intelligence and national security activities authorized by law
- To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official
- For workers compensation and similar programs

OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION

We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by your written authorization, except to the extent we have already relied on your original permission.

INDIVIDUAL RIGHTS

You have the right to ask for restrictions on the ways we use and disclose your health information for treatment, payment and health care operation purposes. You may also request that we limit our disclosures to persons assisting your care or payment for your care. We will consider your request, but we are not required to accept it. You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail.

Except under certain circumstances, you have the right to inspect and copy medical, billing and other records used to make decisions about you. If you ask for copies of this information, we may charge you a fee for copying and mailing.

If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate and complete. You have a right to receive a list of certain instances when we have used or disclosed your medical information. If you ask for this information from us more than once every twelve months, we may charge you a fee. You have the right to a copy of this notice in paper form. You may ask us for a copy at any time. To exercise any of your rights, please contact us in writing at:

John Williams, MD Plastic Surgery
20401 N. 73rd Street, Suite 205
Scottsdale, AZ 85255

When making a request for amendment, you must state a reason for making the request. If you have any complaints concerning our privacy practices or to obtain more information concerning this notice, you may contact our compliance officer: **John Williams, MD at 480-502-5755** YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

If you would like further information, please call our office at: 480-502-5755

HIPAA

Acknowledgment of Receipt of Privacy Notice

I acknowledge that on _____
(Date)

I was provided with a copy of Dr. Williams' **Notice of Privacy Practices,** and

_____ I have read and understand the Notice.

_____ I refuse to sign this acknowledgement.

_____ Patient Representative refuses to sign the acknowledgement.

_____ Comments/Requests _____

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Printed Name of Patient_____

Patient/Guardian Signature_____

Patient Coordinator Signature_____