INNER RIVERS ACUPUNCTURE

HIPAA NOTICE AND AGREEMENT

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

The law requires that the privacy of your health information be maintained and that you are provided with this notices of the legal duties and privacy practices with respect to your health information. Other than the uses and disclosures described below, your health information will not be sold or provided to any outside marketing organization. I must abide by the terms of this notice, and I reserve the right to change the terms of this privacy notice. If a change is made, it will apply to all your health information, and you will be notified in writing.

HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED; AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. USES AND DISCLOSURES

Here are examples of use and disclosure of your healthcare information:

1. I may have to disclose your health information to another healthcare provider, or a hospital, etc., if it's necessary to refer you for the diagnosis, assessment, and/or treatment of your health condition.
2. I may have to disclose your treatment records and your billing records to another party (i.e., your insurance company) if it is potentially responsible for the payment of your services.
3. I may need to use any information in your file for quality-control purposes, or any other administrative purposes to run this practice.
4. I may need to use your name, address, phone number, and your records to contact you to provide appointment reminder calls, recall postcards, "Welcome" and "Thank You" cards, information about our therapies, or other related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message may be left on your answering machine. By signing, you agree to this.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing at the address below. I am not required to honor these requests; but if I agree to a restriction, it is binding on me.

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

Under federal law, I am also permitted or required to use or disclose your information without your consent or authorization in the following circumstances:

1. I am providing services to you based on the orders (referral) of a healthcare provider.
2. I provide services to you in an emergency and am unable to obtain your consent after attempting to do so.
3. If there are substantial barriers to communicating with you, but in my professional judgment, I believe that you intend for me to provide care.

REVOKING YOUR AUTHORIZATION

You may revoke your authorization to me at any time in writing. There are two circumstances under which I will not be able to honor your revocation request:

1. If your information has been released prior to your request to revoke your authorization. 165.508(b)(5)(l)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your information if it decides to contest any of your claims.

CONFIDENTIAL COMMUNICATION

I will attempt to accommodate any reasonable written request regarding your contact information that has been provided by you.

AMENDING YOUR HEALTH INFORMATION

You have the right to request that I amend your health information for 7 years from the date that the record was created or as long as the information remains in my files. I require a written request with the patient's signature to amend your records that includes a valid reason to support the change. I have the right to refuse your request.

INSPECTING/COPYING YOUR HEALTH INFORMATION

You have the right to inspect your files while in the office and/or have a copy made for you. The information is available up to 7 years from the date that the record was created. Your request to inspect or obtain a copy of the file must be in writing. There will be a charge of $0.50 per page copied.

ACCOUNTING OF DISCLOSURES OF YOUR RECORDS

You have the right to request an accounting of any disclosures not listed below made of your information for 6 years prior to the date of your request. The request must be in writing. The accounting will exclude the following disclosures: required for your session; to obtain payment for services; to run my practice and/or made to you; necessary to maintain a directory of the individuals in my facility or to individuals involved in your care; for natural security, intelligence purposes, or to law enforcement officers; and that were made prior to the effective date of the HIPAA privacy law (April 14, 2003). I will provide the first accounting within a 12-month period without any charge, but any additional requests will be charged a fee. When you make your request, I will tell you the amount of the fee, and you will have the opportunity to withdraw or modify your request.

RE-DISCLOSURE

I cannot control the actions of others to whom I have released your information for further treatment.
Information that I use or disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by federal privacy rules.

COMPLAINTS

You may complain to me or to the Secretary of Health and Human Services if you feel I have violated your privacy rights. I respect your right to file a complaint and will not take any action against you if you file a complaint. Written comments should be addressed to my office address:

Inner Rivers Acupuncture
2221 James St.
Bellingham, WA 98225

Signed _____ Date _____

This notice is effective as of January, 2014. This notice will expire 6 years after the date on which the patient signs the health intake and insurance information record.