

# 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. USES AND DISCLOSURES—PLEASE READ THIS IN ITS ENTIRETY AND CAREFULLY**

**TREATMENT:** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professional who may provide treatment or who may be consulted by staff members.

**PAYMENT:** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated. You are required to provide this practice with all insurance coverage information, health, auto and worker's compensation (if applicable), or discuss and provide an alternative method for providing payment for services to this practice.

**HEALTH CARE OPERATIONS:** Your health information may be used as necessary to support the day-to-day activities and management of this practice, Suburban Orthopaedics. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

**LAW ENFORCEMENT:** Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections and to facilitate law-enforcement investigations and to comply with government mandated reporting.

**PUBLIC HEALTH REPORTING:** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's health department.

**OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of you information may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

## **ADDITIONAL USES OF INFORMATION:**

**APPOINTMENT REMINDERS:** Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send your information describing other health-related goods and services that we believe may interest or be of benefit to you.

**INDIVIDUAL RIGHTS:** You have certain rights under the federal privacy standards. These include:

- The right to request restriction on the use and disclosure of our protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections of your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

## **THE DUTIES OF THIS MEDICAL PRACTICE, SUBURBAN ORTHOPAEDICS, PC LOCATED IN LANGHORNE, PENNSYLVANIA**

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice. As permitted by law, we reserve the right to amend or modify our privacy policies and regulations. Whatever the reason for the revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

**REQUEST TO INSPECT INFORMATION:** As permitted by federal regulation, we require that requests to inspect or copy protected health information by submitted in writing. You may obtain a form to request access by asking our receptionist or contacting the Privacy Officer in writing.

**COMPLAINTS:** if you would like to submit a comment or complaint about our privacy practices, or suspect violation, you do so by letter, outlining you concerns. Please address this correspondence to the Privacy Officer care of this medical practice at our current address

The effective date of this notice – October 16, 2002

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

- I. I acknowledge receipt of Notice by signature.

\_\_\_\_\_  
Patient/Guardian Name (Printed)

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

- II. Signature unable to be obtained due to:

- Patient Refused
- Patient Incapable of Signing (explain): \_\_\_\_\_

- Other (explain): \_\_\_\_\_

\_\_\_\_\_  
Office Staff Signature

\_\_\_\_\_  
Date