



Hands On Hands Rehabilitation Center, Inc.

“Comprehensive Upper Extremity Therapy”

NOTICE OF PRIVACY PRACTICES

We protect the privacy of our patient’s health information as required by law, practice standards, and our internal policies and procedures. This privacy statement explains your rights, our legal duties and our privacy practices.

Your Health Information:

THIS NOTICE DESCRIBES YOUR MEDICAL INFORMATION, HOW IT IS USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

We collect, use and disclose information provided by and about you for medically necessary treatment, healthcare payment and operations or when we are otherwise permitted or required by law to do so.

For Treatment: We may use and disclose information about you in providing, coordinating, or managing your treatment and wellness activities. We may provide referring physicians, other providers and other alternative practitioners information about your treatment when they are appropriately involved with the treatment process.

For Payment: We may use and disclose information about you in managing your medical files, to secure treatment authorization, to confirm insurance coverage, for medical billing and receiving payments for medical care through your health plan or other similar entities. We may also provide information to a doctor’s office, hospital, or other health care providers or health plans to confirm your eligibility for benefits, medical diagnosis, treatment and other medically necessary information in order to provide appropriate services and receive payment.

For Health Care Operations: We may use and disclose medical information about you for our operations. For example, we may use information about you to review the quality of care and services you received, to provide you medical file management or coordination of medical services such as between treating therapists or between doctor and therapist.

As Permitted or Required By Law: Information by you may be used or disclosed to regulatory agencies, such as during audits, licensure, or other proceedings; for administrative or judicial proceedings; to public health authorities; or to law enforcement officials, such as to comply with a court order subpoena.

Authorization: Other used and disclosures of protected health information will be made only with your written permission, unless otherwise permitted or required by law. You may revoke this authorization at anytime, in writing. We will then stop using your information for that purpose. However, if we have already used your information based on you authorization, you cannot take back your agreement for those past situations.

Your Rights

Under regulations that will be in effect on April 14, 2003, you will have additional rights over your health information. Under the new rules, you will have the right to:

- ◆ Send us a written request to see or get a copy of information that we have about you, or amend your personal information that you believe if incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as your physician or hospital.
- ◆ Request additional restrictions on uses and disclosures of your health information. We are not required to agree with these requests.

- ◆ Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address if communications to your home address could endanger you.
- ◆ Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment, or health care operations, or the law otherwise restricts the accounting. We are not required to give you a list of disclosures made before April 14, 2003.

Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with us, or with the federal government. You will not be penalized for filing a complaint.

Copies and Changes

You have the right to receive an additional copy of this notice at any time. We reserve the right to revise this notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever privacy notice is currently in effect. We will communicate any changes to our notice through direct mail.

Contact Information

If you want to exercise your rights under this notice or if you wish to communicate to us about privacy issues or to file a complaint with us, please contact our office at: 714-556-2288.

Declaration of Privacy of Health Information

All medical records and other individually identifiable health information used or disclosed by a covered entity in any form, whether electronically, on paper or orally, are covered by the US Department of Health and Human Services (HHS), and are covered by HIPPA (Health Insurance Portability and Accountability Act 1996).

Further, I authorize that the results of any assessments or records given to me may be used in completing evaluations, assessments, treatment plans, progress reports, summary reports, discharge summary reports and medical records and medical billing reimbursement. I understand that such reports will only report aggregated data, and will only be used for health care purposes such as third party payment and physician or other authorized health care provider, treatment or progress reports. I understand I can restrict the uses and disclosures of my medical information. I understand that I have the right to file a formal complaint with a covered provider or health plan or HHS about violations regarding my health and medical records or information.

This release is and shall be binding upon my heirs, assigns, executor and administrators.

Restrictions requested by client: _____

Signature of Patient: _____ Date: _____