

Pocatello Orthopaedics & Sports Medicine Institute, P.A.
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.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The "Act" gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA" we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your Protected Health Information ("PHI") only for each of the following purposes: Treatment, Payment and Health Care Operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be a referral to another provider for diagnostic testing, pain control, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance for payment.
- **Health Care Operations** includes the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute *De-Identified Health Information* by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives, diagnostic test results, or other health related services that may be of interest to you.

Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing at any time and we are required to honor that written request, except to the extent that action has already been taken in reliance on its contents.

You have the following rights with respect to your "PHI", which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of "PHI", including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not required, however, to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of "PHI" from us by alternative means or at alternative locations.
- The right to inspect and copy your Protected Health Information ("PHI").
- The right to amend your Protected Health Information ("PHI").
- The right to receive an accounting of disclosures of your Protected Health Information ("PHI")
- The right to obtain a paper copy of this notice upon request.

We are required by law to maintain the privacy of your "PHI" and to provide you with notice of our legal duties and privacy practices with respect to that information.

This Notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all "PHI" that we maintain. We will post and you may request a written copy of any revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have a right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by
Asking to speak with our Privacy Officer or for
Written inquiries, note "Attention Privacy Officer".

For more information about "HIPAA" or to file a complaint:
U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 or Toll Free (877) 696-6775



Richard A. Wathne, M.D., F.A.C.S., A.B.O.S.
Benjamin Blair, M.D., A.B.O.S.
S. Jeffrey Bray, D.P.M., F.A.C.F.A.S.

Eighteenth Avenue Medical Plaza
333 North 18th Avenue, Suite D-1
Pocatello, Idaho 83201
(208) 233-2100
Fax (208) 233-3146
www.pocatelloorthopaedics.net

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up, among the multiple healthcare providers who may be involved in that treatment, whether directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as quality assessment and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Pocatello Orthopaedics & Sports Medicine Institute, P.A. has the right to change its *Notice of Privacy Practices* from time to time and that I may contact them at any time at the address above to obtain a current copy of the *Notice*.

I understand that I may request in writing that you restrict how my private information may be used or disclosed to carry out Treatment, Payment or Health Care Operations. I also understand that you are not required to agree with my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain this patients signature in acknowledgement of the *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____
