



**PINNACLE HEALTH CARE**

*Taking Health Care to a Higher Level*

## **NOTICE OF PRIVACY PRACTICES**

### **PURPOSE:**

This notice describes how medical information about you may be used and disclosed and how you can get access to the information. Our intent as an organization is to be fully compliant with the Health Insurance and Portability and Accountability Act (HIPPA) of 1996.

### **1. OUR PLEDGE REGARDING MEDICAL INFORMATION**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. This notice will tell you about the ways we may use and share the information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

### **2. OUR LEGAL DUTY**

The law requires us to keep your medical information private. The law also requires that we give you this notice describing our legal duties, privacy practices and your rights regarding your medical information. We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We have the right to make the changes to our privacy practices and the new terms of our notice effective for all medical information including information previously created or received prior to the changes. Before we make a change to our practices we will amend this notice and make the changes available upon request.

### **3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. **We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific medical information use or disclosure may be revoked at any time upon providing us with a receipt of your written intent not to disclose any further medical information.**

### **TREATMENT:**

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you.



**HEALTH CARE OPERATIONS:**

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

**PAYMENT:**

We may use and disclose your medical information for payment purposes.

**ADDITIONAL USES AND DISCLOSURES:**

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

- Notification of family member or personal representative
- Disaster Relief Law Enforcement
- Research in limited circumstances
- Funeral Director, Coroner or Medical Examiner
- Specialized Government Functions
- Court Orders or Judicial and Administrative Proceedings
- Public Health Activities/Health Oversight Activities
- Victims of Abuse, Neglect or Domestic Violence

**4. YOUR INDIVIDUAL RIGHTS**

- You have the right to copies of your medical information
- You must make a request in writing with a medical record release of information
- If you request copies of your medical record for your personal files, a nominal charge will apply to cover our costs.
- You have the right to receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment and health care operations.
- You have the right to request that additional restrictions be placed on our use or disclosure of your medical information. (We will attempt to abide, though we are not required, to the restrictions except in the case of an emergency.)
- You have the right to request that we communicate with you about your medical information by different means (written) or different locations (workplace). This request must be made in writing.
- You have the right to request that we change your medical information. We may deny your request if we do not create the information you wanted changed or for certain other reasons.
- You may respond with a statement of disagreement that will be added to the medical record.



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### **RIGHT TO REVISE PRIVACY PRACTICES:**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state law and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

### **ACKNOWLEDGEMENT:**

I have received the Notice of Privacy Practices form and have had an opportunity to review.

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Signature of Patient

Date

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Power of Attorney or Authorized Signature

Date



## **FINANCIAL POLICY**

The following is a statement of our financial policy which we ask you to read and sign prior to your first appointment. Additionally, we may require you to present your insurance card(s) at your first appointment.

**MEDICARE:**

We are Medicare providers and we do not accept assignment.

**HMO and PPO:**

It is your responsibility to know your benefits regarding covered services, deductibles, copays, coinsurance and referrals. You may call the Member Services phone number on your insurance card for assistance.

**CONTRACTED INSURANCE CARRIERS:**

We will submit a claim to your insurance company for medical visits. If payment is not received within 60 days, the balance will become your responsibility. It will your responsibility to recover the reimbursement from your insurance carrier.

**PRIVATE INSURANCE CARRIERS:**

We will supply you with the necessary paperwork for you to submit the claims to your insurance company for reimbursement. Full payment is required at the time services are rendered.

I have read this policy and understand that regardless of insurance, I am financially responsible for payment of services.

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Signature of Patient

Date

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Printed Name

Date