Notice of Privacy Policies

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive from you
- Information we receive from other healthcare providers
- Information we receive from third party payers

Protected Health is any information that includes:

1. Demographic information

2. Information gathered by this practice as related to my past, present, and future.

3. Information gathered by this office for past, present, future payments for providing healthcare services.

4. Healthcare operations activities including quality assessment activities, credentialing, business management, and other general operations, procedures and/or activities.

You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representative you choose to make your protected health information available to.

Marketing: This office **will not** use your health information for marketing or communications without your written permission.

Disclosure: This office may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information
3. You have the right to request that this office place additional restrictions on the disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have the right to receive all notices in writing

If you have any questions, complaints, or want more information, contact this office:

US Dept. of Health and Human Services. (DHHS) Office of Civil Rights.
200 Independence Ave. S. W. Room 509 F HHH Building, Washington, DC 20201

Consent for the Purposes of Treatment, Payment, and Other Health Care Options

I, _____give consent to Patricia J Ahner, AP, LAc, to use and disclose my Individual Health Information or Protected Health information for these specific purposes:

1. Providing treatment to me
2. Relating to the payment of the services this office has rendered me.
3. The general administrative operations this practice provides me.

I understand that I have the right to request or put restrictions on the use and disclosure of my Protected Health information for the purposes of treatment, payment of healthcare operation of Patricia J Ahner, AP, LAc, but Patricia J Ahner, AP, LAc, is not required to agree to these restrictions. However, if Patricia J Ahner, AP, LAc agrees to such a request, the restriction is binding upon the practice.

Written and Verbal Communication
Please read the following and answer appropriately.

Can this office send newsletters or other written information to your home? YES/NO

Can this office leave a message at your home? YES/NO

Can this office leave a message at your office? YES/NO

Please read the following and initial in the space provided.

_____I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures form of this acupuncture practice before I sign this consent form regarding the use and disclosure of my Protected Health Information.

_____I have the right to revoke this consent, in writing, at any time, exempting the acupuncturists and practice to the extent that they have already relied upon this consent.

_____I have read, reviewed, understand, and agree to the statement of the Privacy Policy for healthcare services in this office. Patricia J Ahner, AP, LAc, has attempted to provide each patient with a statement of Privacy Policies.

Signature of Patient or Personal Representative (relationship to patient) Date

Print Name

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