

PHILIP KELLEY, LICENSED ACUPUNCTURIST

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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)

HIPAA is a federal program which requires that all medical records and other health information are kept confidential. This Act gives you, the patient, rights to understand and control how your health information is used. As obligated by law, 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.

Use and Disclosure With Consent

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of treatment, payment and healthcare operations in this office. Treatment means providing coordination, or managing healthcare related services by one or more healthcare providers. Payment means activities as obtaining reimbursement for services, verifying coverage, billing or collection activities and utilization review. Healthcare operations include the business aspects of running our practice. For example, using your confidential information to remind you of your appointments by leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization.

Use and Disclosure without Consent

In some limited situations, the law requires us to use and disclose your health information without your permission. Examples are: for public health purposes; Medicare audits; law enforcement; orders of the court; and worker's compensation programs.

Your Rights Regarding Your Health Information

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request.

- The right to request restrictions on certain uses and disclosures of protected health information.
- The right to ask us to communicate to you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address.
- The right to ask to see or to get photocopies of your health information. Photocopy and mailing expense is charged to patient.
- The right to receive an accounting of disclosures of protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice or full HIPPA disclosure statement upon request.

Patient Acknowledgement

I acknowledge that I have received a copy of the Notice of Privacy Practices for the practice of Philip Kelley, LAc. PLLC. The notice describes the types of uses and disclosures of my health care information that may occur during treatment, payment for service, and in the performance of office operations. It also describes my rights and responsibilities as well as that of the practice of Philip Kelley with respect to the protected health care information. You have the right to file a formal, written complaint with us or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel that your privacy rights have been violated.

Signature of Patient (or Parent or Guardian)

Date