HearSmart Audiology, LLC

NOTICE OF PRIVACY PRACTICES

EFFECTIVE November 1, 2012

Revised January 29, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. You have the right to a paper copy of this Notice; you may request a copy at any time.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

We may use and disclose your health information for the following purposes without your express consent or authorization.

***Treatment*.** We may use your health information to provide you with medical treatment. We may disclose information to doctors, nurses, technicians, medical students, or other personnel involved in your care. We also may disclose information to persons outside our organization involved in your treatment, such as other health care providers, family members, and friends.

We may use and disclose health information to discuss with you treatment options or health-related benefits or services or to provide you with promotional gifts of nominal value. We may use and disclose your health information to remind you of upcoming appointments. Unless you direct us otherwise, we may leave messages on your telephone answering machine or send electronic mail with an email address that you provided, identifying our organization and asking for you to return our correspondence. We will not disclose any health information to any person other than you except to leave a message for you to return the call.

Payment. We may use and disclose your health information as necessary to collect payment for services we provide to you. We also may provide information to other health care providers to assist them in obtaining payment for services they provide to you.

Health Care Operations. We may use and disclose your health information for our internal operations. These uses and disclosures are necessary for our day-to-day operations and to make sure patients receive quality care. We may disclose health information about you to another health care provider or health plan with which you also have had a relationship for purposes of that provider's or plan's internal operations.

Business Associates. We provide some services through contracts or arrangements with business associates. We require our business associates to appropriately safeguard your information.

***Creation of de-identified health information*.** We may use your health information to create de-identified health information. This means that all data items that would help identify you are removed or modified.

Uses and disclosures required by law. We will use and/or disclose your information when required by law to do so.

***Disclosures for public health activities*.** We may disclose your health information to a government agency authorized (a) to collect data for the purpose of preventing or control disease, injury, or disability; or (b) to receive reports of child abuse or neglect. We also may disclose such information to a person who may have been exposed to a communicable disease if permitted by law.

***Disclosures about victims of abuse, neglect, or domestic violence*.** We may disclose your health information to a government authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

***Disclosures for judicial and administrative proceedings*.** Your protected health information may be disclosed in response to a court order or in response to a subpoena, discovery request, or other lawful process if certain legal requirements are satisfied.

***Disclosures for law enforcement purposes*.** We may disclose your health information to a law enforcement official as required by law or in compliance with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer; a grand jury subpoena; or an administrative request related to a legitimate law enforcement inquiry.

***Disclosures regarding victims of a crime*.** In response to a law enforcement official's request, we may disclose information about you with your approval. We may also disclose information in an emergency situation or if you are incapacitated if it appears you were the victim of a crime.

Disclosures to avert a serious threat to health or safety. We may disclose information to prevent or lessen a serious threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

***Disclosures for specialized government functions*.** We may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

Disclosure for fundraising. We may disclose demographic information and dates of service to an affiliated foundation or a business associate that may contact you to raise funds for our organization. You have a right to opt out of receiving such fundraising communications.

Disclosure for remunerated treatment communications. We may disclose your information for the purposes of communicating treatment alternatives or health-related products or services when we receive payment for your information in exchange for making the communication. You have a right to opt out of receiving such communications.

OTHER USES AND DISCLOSURES

We will obtain your express written authorization before using or disclosing your information for any other purpose not described in this notice. For example, authorizations are required for use and disclosure of psychotherapy notes, certain types of marketing arrangements, and certain instances involving the sale of your information. You may revoke such authorization, in writing, at any time to the extent we have not relied on it.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

Right to Inspect and Copy. You have the right to inspect and copy health information maintained by us. To do so, you must complete a specific form providing information needed to process your request. If you request copies, we may charge a reasonable fee. We may deny you access in certain limited circumstances. If we deny access, you may request review of that decision by a third party, and we will comply with the outcome of the review.

Right To Request Amendment. If you believe your records contain inaccurate or incomplete information, you may ask us to amend the information. To request an amendment, you must complete a specific form providing information we need to process your request, including the reason that supports your request.

Right to an Accounting of Disclosures and Access Report. You have the right to request a list of disclosures of your health information we have made, with certain exceptions defined by law. You also may request an access report indicating who has accessed your PHI maintained by us or our business associates in an electronic designated record set in the last three years. To request an accounting, you must complete a specific written form providing information we need to process your request.

Right to Request Restrictions. You have the right to request a restriction on our uses and disclosures of your health information for treatment, payment, or health care operations. You must complete a specific written form providing information we need to process your request. Our Privacy Officer is the only person who has the authority to approve such a request.

Right to Request Alternative Methods of Communication. You have the right to request that we communicate with you in a certain way or at a certain location. You must complete a specific form providing information needed to process your request. Our Privacy Officer is the only person who has the authority to act on such a request. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

COMPLAINTS

If you believe your rights with respect to health information have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact our Privacy Officer, Megan D. Ford. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

We reserve the right to change the terms of this Notice and to make the revised Notice effective with respect to all protected health information regardless of when the information was created.

AUTHORIZATION AND RELEASE

I authorize the release of pertinent information necessary to process my medical claim. I hereby assign all insurance benefits to which I am entitled, including Medicare, private insurance and any other health plans to **HearSmart Audiology** for services rendered. The assignment will remain in effect until revoked by me in writing. I understand that if my insurance requires a referral, I am responsible for obtaining one prior to my appointment. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all other services rendered on my behalf.

I also authorize **HearSmart Audiology** to release any and all medical information in the course of my treatment to my primary care physician, as well as to:

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(Name) (Location)

LATE CHARGES

If I do not pay the balance within 30 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is repayment for additional services. In the case of default on payment of the account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

HIPAA STATEMENT

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. 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 directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____ Date_____

Relation to Patient_____

Signature_____