

Active Physical Therapy & Wellness, LLC
NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the practice manager at this facility.

The effective date of this Privacy Notice is _____.

At this facility we respect the privacy and confidentiality of your health information. This Notice of Privacy Practices ("Notice") describes how we may use and disclose your medical/health information and how you can get access to this information. This Notice applies to uses and disclosures we may make of all your health information whether created or received by us.

I. OUR RESPONSIBILITIES TO YOU

We are required by law to:

1. Maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices.
2. Comply with the terms of our current Notice.

We reserve the right to change our practices and to make the new provisions effective for all health information we maintain. Should we make material changes, we will make the revised Notice available to you by posting it in a clear and prominent location.

II. HOW WE WILL USE AND DISCLOSE YOUR HEALTH INFORMATION

A. For Treatment, Payment and Health Care Operations

We may use and disclose your health information for purposes of treatment, payment and health care operations as described below.

1. **For Treatment.** We may use and disclose your health information to provide you with treatment and services and to coordinate your continuing care. Your health information may be used by doctors and nurses, as well as by lab technicians, dieticians, physical therapists or others involved in your care, both within and outside our Facility. For example, a pharmacist will need

certain information to fill a prescription ordered by your doctor. We may also disclose your health information to persons or facilities that will be involved in your care after you leave our Facility.

2. **For Payment.** We may use and disclose your health information so that we can bill and receive payment for the treatment and services you receive. For billing and payment purposes, we may disclose your health information to an insurance or managed care company, Medicare or Medicaid or another third party payor. For example, we may contact Medicare or your health plan to confirm your coverage or to request approval for a proposed treatment or service.

3. **For Health Care Operations.** We may use and disclose your health information as necessary for our internal operations, such as for general administration activities and to monitor the quality of care you receive with us. For example, we may use your health information to improve the quality of care you received and for education and training purposes.

B. Other Uses and Disclosures We May Make Without Your Written Authorization

Under the Privacy Regulations, we may make the following uses and disclosures without obtaining a written authorization from you:

1. **As Required By Law.** We may disclose your health information when required by law to do so.

2. **Persons Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose health information about you to a family member, close personal friend or other persons you identify, including clergy, who are involved in your care. These disclosures are limited to information relevant to the person's involvement in your care or in arranging payment for your care.

3. **Public Health Activities.** We may disclose your health information for public health activities.

4. **Reporting Victims of Abuse, Neglect or Domestic Violence.** If we believe that you have been a victim of abuse or neglect, we may disclose your health information to notify a government authority.

5. **Health Oversight Activities.** We may disclose your health information to a health oversight agency for activities authorized by law. A health oversight agency is a state or federal agency that oversees the health care system. Some of the activities may include, for example, audits, investigations, inspections and licensure actions.

6. **Judicial and Administrative Proceedings.** We may disclose your health information in response to a court or administrative order. We also may disclose information in response to a subpoena, discovery request, or other lawful process.

7. **Law Enforcement.** We may disclose your health information for certain law enforcement purposes, including, for example, to file reports required by law or to report emergencies or suspicious deaths; to comply with a court order, warrant, or other legal process; to identify or locate a suspect or missing person; or to answer certain requests for information concerning crimes.

8. **To Avert a Serious Threat to Health or Safety.** When necessary to prevent a serious threat to your health or safety, or the health or safety of the public or another person, we may use or disclose your health information to someone able to help lessen or prevent the threatened harm.

9. **Military and Veterans.** If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities.

10. **National Security and Intelligence Activities; Protective Services for the President and Others.** We may disclose health information to authorized federal officials conducting national security and intelligence activities or as needed to provide protection to the President of the United States, certain other persons or foreign heads of states or to conduct certain special investigations.

11. **Workers' Compensation.** We may use or disclose your health information to comply with laws relating to workers' compensation or similar programs.

12. **Business Associates.** We may disclose your health information to our business associates under a Business Associate Agreement.

C. Your Written Authorization is Required For All Other Uses or Disclosures of Your Health Information

1. We will obtain your written authorization (an "Authorization") prior to making any use or disclosure other than those described above. Most uses and disclosures of your protected health information that are made for marketing purposes or disclosures that constitute a sale of protected health information require your written authorization.

2. A written Authorization is designed to inform you of a specific use or disclosure (other than those described above) that we plan to make of your health information. The Authorization describes the particular health information to be used or disclosed and the purpose of the use or disclosure. Where applicable, the written Authorization will also specify the name of the person to whom we are disclosing the information. The Authorization will also contain an expiration date.

3. You may revoke a written Authorization previously given by you at any time but you must do so in writing. If you revoke your Authorization, we will no longer use or disclose your health information for those purposes specified in the Authorization except where we have already taken actions in reliance on your Authorization.

D. Your Rights Regarding Your Health Information

You have the following rights regarding your health information:

1. **Right to Request Restrictions.** You have the right to request that we restrict the way we use or disclose your health information for treatment, payment or health care operations. However, we are not required to agree to the restriction except under limited circumstances. For example, we must agree to your request to restrict disclosures about you to your health plan for purposes of payment or healthcare operations that are not required by law if the information pertains solely to a health care item or service for which you have paid us in full out of pocket. If we do agree to a restriction, we will honor that restriction except in the event of an emergency.

2. **Right to Request Confidential Communications.** You have the right to request that we communicate with you concerning your health matters in a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number. We will accommodate your reasonable requests.

3. **Right of Access to Personal Health Information.** You have the right to inspect and, upon written request, obtain a copy of your health information.

4. **Right to Request Amendment.** You have the right to request that we amend your health information. Your request must be made in writing and must state the reason for the requested amendment. We may deny your request for amendment under certain circumstances.

If we deny your request for amendment, we will give you a written denial notice, including the reasons for the denial. You have the right to submit a written statement disagreeing with the denial which will be included in your medical record.

5. **Right to an Accounting of Disclosures.** You have the right to request an “accounting” of certain disclosures of your health information.

You must submit your request in writing and you must state the time period for which you would like the accounting. The accounting will include the disclosure date; the name of the person or entity that received the information and address, if known; a brief description of the information disclosed; and a brief statement of the purpose of the disclosure. The first accounting provided within a 12-month period will be free; for further requests, we may charge you our costs for completing the accounting.

6. **Notification of Breaches of Your Health Information.** You have the right to receive written notification of any “breach” of your unsecured protected health information, as that term is defined in 45 CFR §164.402.

E. **Special Regulations Regarding Disclosure of Psychiatric and HIV-Related Information**

For disclosures concerning certain health information such as HIV-related information or records regarding psychiatric care that have been sent to us by another provider, special restriction apply. Generally, we will disclose such information only with an Authorization, or as otherwise required by law.

F. **For Information About This Notice or to Report A Concern Regarding Our Privacy Practices**

1. If you believe that your privacy rights have been violated, you may file a complaint in writing with us or with the Office of Civil Rights in the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Room 509 F, HHH Building, Washington D.C. 20201.

2. To file a complaint with us, you should contact the practice manager of this facility.

3. We will not retaliate against you in any way for filing a complaint against the Facility.

Signature _____

Date _____