NOTICE OF PRIVACY PRACTICES (HIPAA INFORMATION FORM)

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.

NOTICE OF PRIVACY PRACTICES AND INFORMATION PRACTICES

This Notice of Privacy Practices is provided to you by **Pacific Coast Kinesiology Center** (hereinafter "we" or "company" or "practice") as a requirement of Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguard we have in place to protect it. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation.

Acknowledgment of Receipt of this Notice. You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights.

Protected Health Information (PHI). With HIPAA in place, there are rules and restrictions on who we may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service fees and care. Additional information is available from the U.S. Department of Health and Human Services at **www.hhs.gov**

Pacific Coast Kinesiology Center (PCKC) may use and/or disclose your PHI for purposes related to your care, payment for you care, and health care operations of the practice. The following are examples of the types of uses and/or disclosures of your PHI that may occur. There examples are not meant to include all possible types of use and/or disclosure.

We are required by law to do the following:

1. Make sure that your PHI is kept private.
2. Give you this notice of our legal duties and privacy practices related to the use and disclosure of your PHI.
3. Follow the terms of this notice currently in effect.
4. Communicate any changes in the notice to you.

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- Care - In order to provide care to you, the practice will provide your PHI to those health care professionals directly involved in your care so they may understand your medical condition and needs and provide advice or treatment. For example, your physician may need to know how your condition is responding to the treatment provided by PCKC.
- Payment - In order to get paid for some or all of the health care provided by the practice, the PCKC may provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the practice may need to provide your health insurance carrier with information about health care services you received from PCKC to ensure proper payment. Should a third party collections company needs to be notified of your debts, the practice may safely provide them with your information.
- Health Care Operations - In order for the practice to operate in accordance with applicable law and insurance requirements, and in order for the practice to provide quality and efficient care, it may be necessary for PCKC to compile, use and/or disclose your PHI. For example, the practice may use your PHI in order to evaluate the performance of the practice's personnel in providing care to you.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored electronically in a secured medical "cloud" system and on-site will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilize within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone/ text message, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and updates that you might find valuable or informative.

3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

4. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

5. Your confidential information will not be shared or sold to be used for the purposes of marketing or advertising of products, goods or services.

6. We agree to provide patients with access to their records in accordance with state and federal laws.

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7. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

8. Unless you object, we may release protected health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care or who has helped in the past. We may also tell you family or friends of the conditions that you are in, or communicate information to them as we see necessary. You will be provided a form to list specific people who we may speak to regarding you confidential medical and billing details. In addition, we may disclose protected health information about you to an entity assisting in an emergency situation.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

10. We have a sign-in sheet with patient names on the front desk.

11. We may display pictures and note cards sent to our office by patients.

Complaints. Should you wish to discuss information pertaining to your privacy rights and/or how Pacific Coast Kinesiology Center has handled you health information, please contact our practice manager at 949-716-3930. If you are unsatisfied with the manner in which our office manager handles your complaint, you may submit a formal complaint to DHHS, Office of Civil Rights.

I, ______________________________________ date ____________________ do herby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. As required by privacy regulations, I hereby acknowledge that I have reviewed Pacific Coast Kinesiology Center's Notice of Privacy Practices. I understand that this consent shall remain in force from this time forward. I hereby provide Pacific Coast Kinesiology Center with my authorization and consent to use and disclose my protected healthcare information for the purposes of treatment, payment, and healthcare operations as described in this notice.

____
Patient's Name (Please print)

____ ___________________________
Patient, Parent or Legal Guardian Signature Date

____ ___________________________
Witness Signature Date

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HIPAA: MEDICAL AND BILLING DISCLOSURE
CONTACT INFORMATION

I have reviewed Pacific Coast Kinesiology Center's Notice of Privacy Practices (HIPAA Information Form). I hereby give permission to Pacific Coast Kinesiology Center to contact and/or speak to the following individuals or entities regarding my healthcare and billing information as necessary.

Name: ____

Relationship: ____

Phone Number: ____

Name: ____

Relationship: ____

Phone Number: ____

Name: ____

Relationship: ____

Phone Number: ____

____
Patient's Name (Please print)

_______________________________________ ________________________
Patient, Parent or Legal Guardian Signature Date

_______________________________________ ________________________
Witness Signature Date

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