

## **HIPAA NOTICE OF PRIVACY PRACTICES & HIPAA ACKNOWLEDGEMENT**

*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.*

This is your Notice of Privacy Practices from Ascential Acupuncture LLC. The Notice refers to Ascential Acupuncture LLC by using the terms “us”, “we,” or “our.”

Ascential Acupuncture LLC keeps electronic health records (EHR) and applies reasonable safeguards to protect your Personal Health Information and privacy and has implemented the minimum necessary standard with regard to sharing your Personal Health Information. The minimum necessary standard limits how much protected health information is used, disclosed, and requested for certain purposes. We are required by law to maintain the privacy of Personal Health Information, and provide individuals with this notice of our legal duties and privacy practices with respect to personal health information.

### **How We May Use and Disclose Protected Health Information About You**

**For Treatment:** To provide, coordinate, or manage your health care and any related services. This includes the coordination of your health care with a third party. For example, to another healthcare professional to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

**For Payment:** We may use or disclose information for billing, claims management, collection activities, and obtaining payment under a contract for reinsurance and related healthcare data processing.

**For Healthcare Operation:** In order to support the business activities of Ascential Acupuncture. These activities include, but are not limited to, quality assessment activities, employee review activities, training of staff, technicians, nurses, and other healthcare workers for teaching purposes, licensing, fundraising activities, and conducting or arranging for other business activities.

**For Appointment Reminders:** We may contact you to remind you about your appointment for services.

**For Health-related Benefits and Services:** We may use and disclose Protected Health Information to tell you about health-related benefits and services that may be of interest to you.

### **Other Purposes For Which The Law Allows Us To Use Or Disclose Medical Information Without Your Written Authorization:**

**As Required By Law:** We will share your medical information when requires to do so by federal, state, or local law. In the following situations your authorization is not required including; Communicable Disease, Health Oversight, Abuse or Neglect, Food & Drug Administration Requirements, Legal Proceedings, Law Enforcement, Organ Donation, Research, National Security, Worker's Compensation. Inmates; Requires Uses and Disclosures. Under the law, disclosures must be made available to you and are required by the Secretary of the Department of Health and Human Services.

### **Your Rights Regarding Protected Health Information:**

**You Have The Right To Inspect And Copy Your Protected Health Information.** This means you may obtain a

copy of Protected health information about you with a written request. You may obtain your medical record electronically. You may obtain a printed copy for a reasonable fee, as permitted by federal or state law.

**You Have The Right To Request A Restriction Of Your Protected Health Information.** You may ask us not to use or disclose any part of your personal health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family or friends who may be involved in your care. Your request must be written and state the specific restrictions and to whom the restriction will apply.

**You Have The Right To Request To Receive Confidential Communications From Us By Alternative Means Or At An Alternative Location.**

**You May Have The Right To Amend Your Protected Health Information.** If denied, you have the right to file a statement of disagreement.

**You Have The Right To Receive An Accounting Of Certain Disclosures We Have Made, If Any, Of Your Protected Health Information.**

**You Have The Right To Obtain A Paper Copy Of This Notice** From Us, Upon Request, Even If You Have Agreed To Accept This Notice Electronically.

**You Have The Right To Be Notified Of A Data Breach.** We will keep your medical information private and secure as required by law. If any of your medical information which is acquired, accessed, used or disclosed in a manner that is not permitted by law we will notify you within 60 days following the discovery of a breach.

**Your Authorization:** Certain uses of your medical data, such as use of patient information in marketing, require prior disclosure and your authorization. Uses and disclosures not described in this notice will be made only with your authorization. If you give your permission to use or share your Personal Health Information, you may cancel that permission, in writing, at any time.

**Your Right to File a Complaint.** You may complain to Ascential Acupuncture or to the Secretary of Health and Human Services if you believe your rights have been violated.

**Effective Date.** This notice was published and becomes effective on January 18, 2018

#### **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT**

Your signature on this document acknowledges that you have received a copy of Ascential Acupuncture LLC's Notice of Privacy Practices. We encourage you to read it in full.

**By signing/e-signing, I agree that I read and understood my privacy rights in this Notice.**

\_\_\_\_\_ **Name On File** \_\_\_\_\_ (Print Name)    \_\_\_\_ **On File** \_\_\_\_ (Date of Birth)

\_\_\_\_\_ **e-Signature On File** \_\_\_\_\_ (Signature of Patient or legally authorized person)

\_\_\_\_\_ **Date On File** \_\_\_\_m nm\_\_ (Current Date)