Notice of Privacy Practices (HIPAA) and Patients' Rights

Acupuncture practice of Lisa Sherman L.Ac. (Asheville Integrated Acupuncture)

Please review the information below carefully

This notice describes how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is protected by our office.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA)

HIPPA is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form are kept confidential. This act provides the patient rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

Our Legal Responsibility

We understand that information about you and your health is very personal. We value and respect your right to privacy. As required by law, we strive to protect the privacy of your health information. We have prepared this explanation of how we are legally required to maintain your privacy and how we may use and disclose your health care information.

We respect our legal obligation to keep health information that identifies you private. We will only use and disclose your Protected Health Information as allowed by applicable law. We will not use your health information inside our office our outside without your written permission. In some limited cases, the law may require us to disclose your health care information without either a written or verbal consent.

We gather personal information and health information in several ways:

- Information we receive from you
- Information we receive from other health care providers

Protected Health Information

is any information that includes information about health status, provision of health care, or payment for health care that can be linked to a specific individual.

Safeguards in place at our office include

- Limited access to facilities where information is stored.
- Policies and procedures for handling information and medical records.

Use and Disclosure With Consent

We will ask you to sign a one-time general consent form, allowing us to use and disclose your health information for purposes of treatment, payment, and health care operations in this office. This general written consent is obtained the first time we provide you with treatment or services. This general written consent is a broad permission that does not need to be repeated each time we provide treatment or services to you. We are allowed to refuse to treat you if you do not sign the consent form.

We will use use your Protected Health Information for the purposes of treatment, payment and health care operations.

Treatment, payment and health care operations

For purposes of treatment: We will use your health care information to treat you. For example, we will use your information to help us diagnose and design a course of treatment for you. Your treatment may include acupuncture, massage and herbs. We may disclose patient health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations. For example, on occasion, it may be necessary to seek consultation regarding a patient's condition from other health care providers. We may also, for the purpose of treatment, disclose your Protected Health Information to another health care provider outside this clinic in order to coordinate your care such as scheduling lab work.

For payment services: We will use your health care information to receive payment for services and products. We will bill you for the cost of treatment and herbs provided to you. The information on or accompanying the bill may include your identification, as well as the herbs you are taking.

For health care operations: We may use and disclose your Protected Health Information for all activities that are included within the definition of 'health care operations' as defined in the Federal Privacy Regulations.

Other uses and disclosures of Protected Health Information permitted or required by regulation

Friends and family: Unless you request otherwise, we may use or disclose health information to a family member or other personal representative to the extent necessary to help with your health care or with payment for your health care.

Reminders: We may call a patient's home to confirm a scheduled appointment or may send an appointment reminder by email. We may leave a reminder message on the answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of the scheduled appointment along with a request to call our office if there is a need to cancel or reschedule the appointment.

Other covered entities: We may disclose Protected Health Information to another covered entity to conduct health care operations in the area of quality assurance activities, certification, licensing or credentialing.

We will obtain your written authorization before using or disclosing your protected health care information for purposes other than those listed above or otherwise permitted or required by law.

You may specifically authorize us to use Protected Health Information for any purpose or to disclose (share) your Protected Health Information by submitting an authorization in writing. Such disclosures will be made to any personal representative to whom you choose to make your Protected Health Information available.

You may revoke authorization in writing at any time. Upon receipt of this revocation we will stop using or disclosing your protected health care information except to the extent that we have already taken action in reliance on the authorization.

Use and Disclosure Without Consent

In some limited situations, the law requires us to use and disclose your health information without your permission. These examples include:

- When state or federal law mandates certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
- Disclosure to government authorities about victims or suspected abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of health care laws.
- Disclosures in response to subpoenas of orders of the court.
- Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime in our office.
- Disclosure related to worker's compensation programs.

Patient Rights

As a patient you have the following rights:

1. RIGHT TO INSPECT AND COPY. Upon written request you have the right to access, review or receive copies of your health care records.
2. RIGHT TO AN ACCOUNTING OF DISCLOSURES. Upon written request you have the right to receive a list of items this office has disclosed about your Protected Health Information.
3. RIGHT TO REQUEST RESTRICTIONS. You have the right to request that this office place additional restrictions on the disclosure of your Protected Health Information.

4. RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS Patients have the right to have their Protected Health Information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon their request. For example, patients can ask that we only contact them at work or by mail.
5. RIGHT TO AMEND. You have the right to request that we amend your Protected Health Information, in the event that you believe the health information we have is incorrect or incomplete. This request must be in writing. Please be advised, however, that we are not required to agree to amend Protected Health Information. We may deny the request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny the request if the patient asks us to amend information that:
   A. We did not create, unless the person or entity that created the information is no longer available to make the amendment.
   B. Is not part of the health information that we keep.
   C. You would not be permitted to inspect and copy.
   D. Is accurate and complete.
   If the patient request to amend health information has been denied, the patient will be provided with a explanation of our denial reason(s) and information about how to disagree with the denial.
6. RIGHT TO A PAPER COPY. You have the right to receive a paper copy of this Notice of Privacy Practices at any time upon request.

Questions and Complaints

If you have any questions, complaints, or want more information, contact this office. If you believe that your privacy rights have been violated, you may file a complaint with us.

Lisa Sherman L.Ac., Asheville Integrated Acupuncture, 30 Clayton Street, Asheville, NC 28801

If you are not satisfied with the manner in which this office handles your complaint, you also have the right to file a formal, written complaint with the Secretary of the US Department of Public Health and Human Services.

US Dept. of Health and Human Services (DHHS), Office of Civil Rights,
200 Independence Ave SW, Room 509 F HHH Building, Washington, DC 20201

We support your right to protect the privacy of your protected health and financial information. We will not retaliate in any way if you choose to file a complaint with us or the Department of Health and Human Services.

Effective Date: January 1, 2014

Consent for the Purposes of Treatment, Payment, and Other Health Care Options

I, _____ give consent to Lisa Sherman L.Ac., and Asheville Integrated Acupuncture, to use and disclose my Protected Health Information for these specific purposes:

1. Providing treatment to me.

2. Relating to the payment of the services this office has rendered me.

3. The general health care operations of this practice.

I understand that I have the right to request or put restrictions on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or health care operations of Lisa Sherman L.Ac., and Asheville Integrated Acupuncture, but Lisa Sherman L.Ac., and Asheville Integrated Acupuncture, is not required to agree to these restrictions. However, if Lisa Sherman L.Ac., and Asheville Integrated Acupuncture agrees to such a request, the restriction is binding upon the practice.

Written and Verbal Communication

Please read and answer the following:
Can this office send newsletters or other written information to your email address? YES/NO
Can this office send newsletters or other written information to your home? YES/NO
Can this office send you an appointment reminder by email? YES/NO
Can this office leave a phone message at your home? YES/NO
Can this office leave a phone message at your office? YES/NO

Please read the following and initial in the space provided:

_____ I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures form of this acupuncture practice before I sign this consent form regarding the use and disclosure of my Protected Health Information.

_____ I have the right to revoke this consent, in writing, at any time, exempting the acupuncturists and practice to the extent that they have already relied upon this consent.

Request for restrictions to use and disclosure of my Protected Health Information

I request the following restrictions to the use of disclosure of my health information:

_____

_____

_____

_____

_____ Print name

_____ Signature

_____ Date

Acknowledgement of receipt of Notice of Privacy Practices (HIPAA) and Patients' Rights

I acknowledge receipt of a copy of the Notice of Privacy Practices (HIPAA) and Patients' Rights of Lisa Sherman L.Ac., and Asheville Integrated Acupuncture.

_____ Print name

_____ Signature

_____ Date