

# **NOTICE OF PRIVACY** **PRACTICES**

**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.**

## **Who We Are**

This Notice describes the privacy practices of South Shore Physical Therapy (the "Practice") their therapists, nurses, and other personnel. It applies to services furnished to you at our office(s).

## **Our Privacy Obligations**

We are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of our legal duties and privacy practices with respect to your PHI. When we use or disclose your PHI, we are required to abide by the terms of this Notice.

## **Permissible Uses and Disclosures Without Your Written Authorization**

In certain situations we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

- ❑ Uses and Disclosures For Treatment, Payment and Health Care Operations. We may use and disclose your PHI in order to treat you, obtain payment for services provided to you and conduct our health care operations as detailed below:
  - Treatment. We use and disclose your PHI to provide treatment and other services to you - for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also disclose PHI to other providers involved in your treatment.
  - Payment. We may use and disclose your PHI to obtain payment for services that we provide to you.
  - Health Care Operations. We may use and disclose your PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you.
- ❑ Other Permitted Or Required Disclosures:
  - Use or Disclosure for Directory of Individuals in the Practice. We may include your name, location in the Practice, general health condition and religious affiliation in a patient directory without obtaining your authorization *unless* you object to inclusion in the directory or are located in a specific ward, wing or unit the identification of which would reveal that you are receiving confidential healthcare treatment.
  - Disclosure to Relatives, Close Friends and Other Caregivers. We may use or disclose your PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present. If you are not present we may exercise our professional judgment to determine whether a disclosure is in your best

- interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that we believe is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose your PHI in order to notify such persons of your location, general condition or death.
- Fundraising Communications. We may disclose to our fundraising staff demographic information about you (e.g., your name, address and phone number) and dates on which we provided health care to you, without your written authorization.
  - Public Health Activities. We may disclose your PHI to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.
  - Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose your PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.
  - Health Oversight Activities. We may disclose your PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.
  - Judicial and Administrative Proceedings. We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.
  - Law Enforcement Officials. We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.
  - Decedents. We may disclose your PHI to a coroner or medical examiner as authorized by law.
  - Organ and Tissue Procurement. We may disclose your PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.
  - Research. We may use or disclose your PHI without your consent or authorization if our Institutional Review Board approves a waiver of authorization for disclosure.
  - Health or Safety. We may use or disclose your PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.
  - Specialized Government Functions. We may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.
  - Workers' Compensation. We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

- As required by law. We may use and disclose your PHI when required to do so by any other law not already referred to in the preceding categories.

### **Uses and Disclosures Requiring Your Written Authorization**

- Use or Disclosure with Your Authorization. For any purpose other than the ones described above, we may only use or disclose your PHI when you grant us your written authorization on our authorization form.
- Marketing. We must also obtain your written authorization prior to using your PHI to send you any marketing materials.
- Special Authorization. Confidential HIV-related information, psychotherapy notes, or substance/alcohol abuse information will never be used or disclosed to any person without your specific written authorization, except to certain other persons who need to know such information in connection with your medical care, and, in certain limited circumstances as required by law.

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

- Right to Access Your Protected Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from the Privacy Office and submit the completed form to the Privacy Office.
- Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your PHI for treatment, payment and health care operations, or to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from our Privacy Office and submit the completed form to the Privacy Office. We will send you a written response.
- Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.
- Right to Revoke Your Authorization. You may revoke your Authorization except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Office identified below.
- You should take note that, if you are a parent or legal guardian of a minor, certain portions of the minor's medical record will not be accessible to you (for example, records relating to venereal disease, abortion, or care and treatment to which the minor is permitted to consent himself/herself (without your consent) such as HIV testing, sexually transmitted disease diagnosis and treatment, chemical dependence treatment, prenatal care, care received by a married minor, and contraception and/or family planning services).
- Right to Amend Your Records. You have the right to request that we amend Protected Health Information maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Privacy Office and submit the completed form to the Privacy Office. We will comply

with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

- Right to Receive An Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003.
- Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.
- For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

#### **Effective Date and Duration of This Notice**

- Effective Date. This Notice is effective on April 14, 2003.
- Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in waiting areas around the Practice. You also may obtain any new notice by contacting the Privacy Office.

#### **Privacy Office**

- You may contact the Privacy Office at:  
Privacy Office  
South Shore Physical Therapy P.C.  
220 Main Street  
Center Moriches, NY 11934  
Telephone Number: (631) 878-4545      E-mail:Bill@Herro.com

#### **ASSIGNMENT OF BENEFITS**

I authorize and assign all medical benefits and rights to the provider of services, as shall equal to the full amount of the such services.  
I understand that if for any reason the insurance company refuses to pay all or part of my claim, that I am personally responsible for full payment of such bill.  
I agree to direct all insurance payments, if made to myself by the insurance company, to the provider of services.

#### **Acknowledgment**

By my signature below, I hereby acknowledge my receipt of this Notice of Privacy Practices, and I acknowledge that the Practice will use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting health care operations.

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Signature of Patient or of  
Personal Representative or of  
Parent

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Date