

**ACKNOWLEDGMENT OF RECEIPT OF OUR
NOTICE OF PRIVACY PRACTICES**

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I _____ have received a copy of this office's Notice of Privacy Practices. *You have the right to refuse to sign this document*

(Please Print Name)

(Signature)

Date: _____

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

- The patient or individual refused to sign this document
- Communications conflicts prohibited us from obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

HIPAA



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HIPPA Policy

HIPAA Notice – NOTICE OF PRIVACY PRACTICES

This HIPAA notice explains in detail how your medical information may be used. We are required to disclose how you can access your information. It is up to you to review this information in full and if you have any questions or concerns to contact us to discuss them.

Legal Obligations

There are federal and state laws that require us to keep your health information private. These same laws also mandate that we provide you with full notification about all practices that apply to your privacy. This includes our legal obligations as well as your rights as they pertain to your personal health information. All privacy practices are exactly as included in this notice and remain in effect from June 30, 2014 until the date we update this notice.

Changes in policy

While we reserve the right to change the terms of this policy, we also agree that an updated notice will be available both on our site and from our office. You can contact us at any time for a printed copy if you require one. This notice will contain provisions regarding all of your health information that we keep in your file.

Effective Date

The effective date of this HIPPA policy is June 30, 2014.

You may request a copy of our HIPPA policy at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us at any time.

How we use your health information

Your health information may be disclosed for treatment purposes, payment purposes or for various healthcare operations. Information may be used as follows:

To provide optical goods or services your information may be provided to a health care provider for the purposes of treatment. To coordinate all related services, consultations or referring to another professional, this information would be disclosed. It may also be used in the event of a recall on a product.

Your insurance company may require us to disclose medical information as part of filing a claim for payment. We may be required to disclose information to determine if your

treatment plan will be covered by your insurer, to determine your coverage level and to help us manage our internal billing system.

Appointments and treatment options may also require us to disclose information. This may include postcards, letters or voicemails to other parties. We may offer additional benefit options or other services that we believe would be of value to you. These may require us sharing your health information.

Our practice often requires us to conduct training programs, undergo accreditation or certification and includes licensing and credentialing. As part of these processes we reserve the right to review all client records in connection with these activities. As part of our overall operation, we may need to disclose your information to other companies that have relationships with you such as your health insurance providers.

Our business associates have contracts that may require us to disclose your health information to them. This may include (but may not be limited to) lawyers, third party billing services, consultants and accountants. We have contracts with these associates that do require they provide full confidentiality of your private health information.

Your family members, friends or you may need help with your healthcare or payment for your healthcare. In this instance if you agree (or fail to object) we may disclose this information to them for any purpose. This also applies if you are not able to agree or disagree.

In the event that you are incapacitated, during an emergency or unable to object to such use, we reserve the right to contact a family member, personal representative or other person who is assisting you with obtaining health services. We will notify you prior to disclosing such information and you are free to object if you are capable of doing so in our best judgment. We must use our experience and best judgment to make reasonable assumptions that are in your best interest to allow someone to pick up forms for your health care, health care information, eyewear or medical supplies.

From time to time we may be required by law to disclose your health information. We will do this when we are required for use in administrative proceedings, when requested by a court or other law enforcement official. We will also disclose this information if we have reason to believe you are a potential victim of domestic abuse, neglect, or a potential victim of other crimes.

If we believe that your information is required for public health activities, Workers' compensation matters or other health oversight activities we will disclose your information if we believe it is necessary for the health and safety of you or others.

If you are a member of the Armed Forces we may be required to disclose your health information for lawful intelligence, counter-intelligence or for other security activities. Your personally protected information may also be disclosed to any correctional institution or law enforcement agency who has lawful custody of you.

You are encouraged to verify your own states laws. The state where you obtain goods or services may offer you additional privacy rights.

We may request that you provide us in writing additional authorization to use your health information. Such authorizations may be revoked at any time, in writing. Revocation does not impact our ability to use information while it is in effect. Without your written

authorization, we cannot utilize your personal health information for any reason except those disclosed in this HIPPA policy.

Your Rights

Under HIPPA disclosures, we own all records relating to the goods and services you obtain from us. You have the right to the following:

Right to request restriction of use (we are not required to honor such request)

Right to confidentiality – you may request we contact you only at work or by mail (request must be in writing)

Right to copy or review – you may request in writing a copy of all information or review of your information in our office

Right to change – you have the right to request information be changed that you feel is not accurate or not complete. This request must be made in writing with an explanation.

Right to summary – you have the right to request in writing a copy of whom your information has been disclosed to.

Right to Physical copy – you have the right to request a paper copy of this notice.

To report a problem

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services, Office of Civil Rights, HIPPA, 200 Independence Avenue, S.W., Washington, DC 20201. We are bound by law to not retaliate should you file a complaint.

GLENDALE 805 N 51ST AVE BLDG 8 STE 160 GLENDALE, AZ 85309	AVONDALE 2101 N 190TH AVE STE 114 PHOENIX, AZ 85027	CENTRAL 1711 N 116TH ST STE 111 PHOENIX, AZ 85026	N. CENTRAL 3201 N PRISON AVE STE D-001 PHOENIX, AZ 85007	AHWATUKEE 4126 E ARLING RD BLDG 9 STE 102 PHOENIX, AZ 85004	MESA 3445 S GILBERT RD STE 101 MESA, AZ 85212	CHANDLER 1121 W BUCKLEUP RD STE 104 CHANDLER, AZ 85225	SURPRISE 14011 W 60TH ST STE 102 SURPRISE, AZ 85179	N.PHX/SCOTTSDALE 14555 N 40TH ST STE 101 PHOENIX, AZ 85032	TUCSON 6940 E KONGHU ST 104 TUCSON, AZ 85712
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