GEORGE ERB
PHYSICAL THERAPY INC.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DECRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

We may use your protected health information (PHI) for the purpose of treatment, payment and health care operations.

- **Treatment** includes the disclosure of health information to other providers involved in your care for the purpose of coordinating and managing your care. This may include doctors, nurses, technicians and other physical therapists.
- **Payment** includes the disclosure of health information to obtain reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** includes the utilization of your records for the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

Uses and Disclosures Required by Law

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurance that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release PHI about you when it is determined to be necessary by the appropriate military authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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 must obtain authorization from you for uses and disclosures of your PHI for marketing purposes and disclosures that constitute a sale of PHI.

Other uses and disclosures not described n this Notice of Privacy Practices will be made only with authorization from you.

We must notify you following a breach of unsecured PHI.

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Your Privacy Rights

- **Restrictions:** you have the right to request restrictions on how your PHI is used. However, we are not required to agree with your request. If we do agree, we must abide by your request. An example would be those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you

  If you pay out-of-pocket in full for your health care services, you have the right to restrict disclosures of your PHI to your health plan.

- **Confidential Communication:** you have the right to reasonable requests to receive confidential communications or PHI from us by alternative means or at alternative locations.
- **Access to PHI**: you have the right to inspect and or request a copy of your medical record. You must make this request in writing.
- **Accounting of Disclosures:** you have the right to receive an accounting of disclosures of protected health information. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.
- **Amendments:** you have the right to request an amendment be made to your PHI if you disagree with what is said about you. This request must be made in writing. If we disagree with you, we are not required to make the change. We may not amend parts of your medical record that we did not create.
- **Fundraising Communications:** you have the right to opt out of being contacted or receive fundraising communications from our office.

Our Duty to Protect Your Privacy

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

- **Complaints:** if you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Video Surveillance Consent:

For your added protection, when entering George Erb Fitness Center as part of your physical therapy treatment, or as part of your physical therapy ingress/egress into our clinic, be advised that George Erb Fitness Center provides 24-hour video surveillance recording both inside the gym and outside the building for your enhanced security, and you hereby consent to such surveillance and recording.

For more information about our privacy practices please contact us at:

George Erb Physical Therapy, Inc
231 Camarillo Ranch Rd
Camarillo, CA 93012

For more information about HIPAA or to file a complaint:

US Department of Health & Human Services / Office of Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201
202-619-0257
Toll Free: 877-696-6775

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HIPAA Consent & Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have reviewed the Notice of Privacy Practices and understand that I may have a copy upon request. I further acknowledge that a complete and current copy of this notice is posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Relation to patient: _____

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on used and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: _____ □ OK to leave a message with details □ Leave a message with call-back number only	**Written Communication:** □ OK to mail written communication to my home address □ OK to mail written communication to my work/office address
Work Telephone: _____ □ OK to leave a message with details □ Leave a message with call-back number only	**I give authorization for GEPT to leave a message in my absence with:** _____ **Indicate relation to patient:** _____ **For matters regarding:** □ my appointment reminders □ my account such as billing and amount due □ my treatment/test results
Cell Phone Number: _____ □ OK to leave a message with details □ Leave a message with call-back number only	

_____ _____

Signature of Patient, Parent or Legal Guardian **Date**

For office use only:

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for Treatment Records, Payment Information and Healthcare Operations may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

(This section below is to be completed by Office Staff only when disclosing records)

Date	Disclosed To Whom Address or Fax	(1)	Description of Disclosure/Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type Key: T = Treatment Records; P = Payment Information; O = Healthcare Operations
(3) Enter how disclosure was made; F = Fax; P = Phone; E = Email; M = Mail; O = Other