

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, unless you exclude otherwise upon signing receipt of acknowledgement at this time.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your

healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing by using the contact information listed at the beginning of this Notice to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge a cost-based fee for providing your health information in the format requested. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the beginning of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to submit a written request to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to submit a written request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to submit a written request that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to submit a written request that we amend your health information, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

For more information about our privacy practices or if you have questions or concerns, please contact our office using the information listed at the beginning of this Notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the beginning of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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

**ACKNOWLEDGEMENT OF
NOTICE OF PRIVACY PRACTICES**

I, _____, acknowledge that I have been
(Name of Patient)

informed of Midwest Plastic Surgery Institute's Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(Please Print Name of Patient or Parent/Guardian if Minor)

(Signature of Patient or Parent/Guardian if Minor)

(Date)

For Office Use Only

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

PRIVACY PRACTICES ACKNOWLEDGEMENT & CONSENT

- I have received the Notice of Privacy Practices and/or have been provided an opportunity to review it.

I agree that I can be contacted regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI"), at the following telephone numbers, in addition to any other numbers provided to you by me:

(____) ____ - ____ Home / Office / Cell / Other: _____
(____) ____ - ____ Home / Office / Cell / Other: _____
(____) ____ - ____ Home / Office / Cell / Other: _____

*as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its regulations, as may be amended from time-to-time

● I understand that it is your policy not to reveal PHI on voicemail systems and answering machines, aside from upcoming appointment information. If I would like to permit you to leave non-appointment PHI messages on the voicemail systems or answering machines at the numbers I have provided, I will initial here: _____

- I understand that it is your policy not to reveal PHI to my spouse, unless I enter his/her name below. I understand that it is your policy, in compliance with the law, to reveal PHI with my other physicians.
- I understand that it is your policy to email information and confirmation messages to the email address(es) I provided you. I also understand that this method of communication is one-way only, and that I may not contact the practice via email, neither for medical nor administrative matters.
- I agree that my PHI may be shared with the following other people (please indicate relationship):

_____ (____) ____ - ____
_____ (____) ____ - ____
_____ (____) ____ - ____

[Please place a star next to the name of the person you choose as your primary emergency contact.]

I understand that it is your policy that, when you receive telephone calls to discuss my medical care or records, all callers, including myself, will have to supply information that uniquely identifies me, such as the last 4 digits of my social security number and/or my birth date, and that without such a match no PHI will be revealed.

I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Midwest Plastic Surgery Institute, Inc.

Patient Name (print): _____

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.