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.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA,” we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may be and disclose your health information.

We may use and disclose you medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining 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** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

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.

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.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Contact at 65 Lafayette Road, North Hampton, NH 03862, ATTENTION: Practice Manager.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We, however, are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures to protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice will expire six (6) years from the date of signing.

This notice is effective as of July 25, 2012 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request, a written copy of a revised Notice of Privacy Practices from this office.

You are recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office or the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Center for Asthma, Allergy and Respiratory Disease,
PLLC Exeter/Hampton Diagnostics, Inc.
65 Lafayette Road, 2nd Floor
North Hampton, NH
03862 (603) 964-3392

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human
Services Office of Civil Rights
200 Independence Avenue,
SW Washington, DC 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be available to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessment and physician certifications.
- Other (please list, such as spouse, parent/s . . .): Please print ____

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I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient name: ____

Relationship to patient: ____

Signature: ____

Date: ____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgment of this notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:

NOTIFICATION OF LIABILITY

I have had the opportunity to read/receive a copy of the privacy policy of Center for Asthma, Allergy and Respiratory Disease, PLLC and hereby authorize any licensed physician, practitioner, hospital, clinic or other medical facility or its representatives to release any and all information with respect to any illness or injury, medical history, consultation, prescription(s) or treatment and copies of all medical records to the physicians of Center for Asthma, Allergy and Respiratory Disease, PLLC. I also authorize Center for Asthma, Allergy and Respiratory Disease, PLLC, its physicians and providers to release medical records to the insurance company responsible for my health coverage should it become necessary for payment of services provided.

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Patient/Guardian signature Date

I hereby assign benefits and authorize payment to go directly to Center for Asthma, Allergy and Respiratory Disease, PLLC for any medical service provided but not to exceed the reasonable and customary charges for these services. This office is not responsible for incorrect benefit information given to us by your insurance carrier or for changes in coverage. A description of benefits is not a guarantee of coverage and cannot be relied on as such. In the event of non-payment by your insurance company, the charges on your account will be your responsibility. I understand that I am financially responsible to the physician for all charges not covered by this agreement. Payment is due at the time services are rendered.

We accept Visa, MasterCard, Discover, American Express, personal checks and cash for your convenience. Knowing your insurance benefits are the responsibility of the insured and dependents.

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Patient/Guardian signature Date

A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.