

aFresh Med Spa & Plastic Surgery

Notice of Privacy Practices

This notice describes how your health information (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable or personal health information (PHI). This information is required by the privacy regulations created in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please review this notice carefully.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

Our practice must provide you with the following important information

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

We may use and disclose your PHI in the following ways

- Treatment: Our practice may use your PHI to treat you by providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may request laboratory tests and use the results to reach a diagnosis. This information may also be given to other health care providers or organizations who may become involved in your care and treatment. We might use your PHI in order to write a prescription and might disclose your PHI to a pharmacy and access your PHI from other pharmacies.
- Payment: Our practice may disclose your PHI in order to obtain reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover your treatment. If you desire to finance the costs of your treatments, this may involve disclosing relevant protected private information in order to obtain approval. We may also have contact with, and provide your PHI to, any financial institutions that you use for payment for your treatment.
- Health Care Operations: Our practice may use your PHI to operate our business, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to see you.
- Appointment Reminders: Our practice may use and disclose your PHI to contact you and remind you of an appointment.
- Electronic Transmission: Our practice may display the office name, address, and patient identifiable information on electronic transmission of insurance claims and statements.
- Release of Information to Family/Friends: Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you.

Use and disclosure of your PHI in certain circumstances:

- For public health activities including reporting of certain communicable diseases.
- To authorities when we suspect abuse, neglect, or domestic violence.
- To health oversight agencies.
- For judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes such as military service or for national security.
- In the event of an emergency or for disaster relief.
- For Worker's Compensation or similar programs as required by law.
- Inclusive of any other instance required by law.

Your rights regarding your PHI

- Confidential communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location.
- Requesting Restrictions: You have the right to request a restriction in our use of disclosure of your PHI treatment, payment or health care operations
- Inspection of Copies: You have the right to inspect and obtain copy of the PHI that may be used to make decisions about you, including patient medical records and billing records. Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding and PHI that is subject to law that prohibits access to PHI.
- Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing providing a reason that supports your request.
- Accounting of Disclosures: All patients have the right to request an "accounting of disclosures" consisting of a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. For example, the provider sharing information with the medical assistant, or the billing department using information to file your insurance claim.
- Right to a Paper Copy of this Notice: You are entitled to receive a paper copy of our notice of privacy practices.
- Right to File a Complaint: If you believe your privacy rights have been violated, you may file a written complaint with our office, or with the Department of Health and Human Services, or the Office of Civil Rights.
- Right to Provide an Authorization for Other Uses and Disclosures: Our practice will obtain written authorization for uses and disclosures that are identified by this notice or permitted by applicable law.

Our practice is required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change terms of our Notice of Privacy practices and to make the new provisions effective for all protected health information that we maintain.

aFresh Med Spa & Plastic Surgery
Patient HIPAA Agreement and Authorization

CONSENT TO LEAVE MESSAGES

Regarding my treatment and any follow up communication, I agree to be contacted by the phone numbers (including text) and email addresses that I provided in my Confidential Health Questionnaire. I also give permission to leave relevant medical information on voicemail messages.

In addition, I allow the following phone numbers for communication:

Cell phone: _____	Print Name: _____
Home phone: _____	Print Name: _____
Other phone: _____	Print Name: _____

I give permission to give medical information, and discuss my medical care, with the following:

Spouse: _____
Parents: _____
Children: _____
Friends: _____

Please Note:

- Your photograph may be taken to document your condition or treatment and will be part of your medical record.
- If your medications or health history changes, please let us know when you check in for your appointment.
- Please silence your cell phone if possible. For your safety, no children are allowed in the treatment rooms unless discussed with your provider.
- We require at least 48 hour notice to cancel or reschedule your appointment. Unless agreed to otherwise, if you cancel less than 48 hours or if you are a no show for an appointment, there may be a \$100 fee.
- If you have any question regarding your treatment, please contact your provider or the Practice Manager at 847-786-5200.

ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I was offered or provided with a copy of the HIPAA Notice of Privacy Practices. I read, understand my rights, and agree with the Notice of Privacy Practices and items noted on this form. **For more information about HIPAA or if you have any questions about this notice, please contact: Info@aFreshMedSpa.com or Ellen@DrGutowski.com.**

Patient Name: (print) _____

Patient or Guardian Signature Date

FOR STAFF:

I attempted to obtain this patient's signature but was unable to for the following reason:

Staff Name: (print) _____ Date: _____