

**PRIMECARE MEDICAL CLINIC
NOTICE OF PRIVACY PRACTICES**

April 14, 2003

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to 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 IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

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

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer, PrimeCare Medical Clinic, 205 E Race St, Searcy, Arkansas, 72143, (501)279-9000

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice- including, but not limited to, our doctors and nurses- may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We may also use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

OPTIONAL

- 4. Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

OPTIONAL

- 5. Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

OPTIONAL

- 6. Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL

- 7. Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your IIHI.

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury, or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related to primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena, or similar legal process
- To identify/locate a suspect, material witness, fugitive, or missing person
- In an emergency, to report a crime(including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

OPTIONAL:

- 5. Deceased Patients.** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we may also release information in order for funeral directors to perform their jobs.
- 6. Organ and Tissue Donation.** Our practice may release your IIHI to organizations that handle organ, eye, or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation or transplantation if you are an organ donor.
- 7. Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an IRB or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to the individual's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be reused or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to use of the PHI.

8. Serious Threats to health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary; (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. 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. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to **Privacy Officer, PrimeCare Medical Clinic, 205 E Race St, Searcy, AR 72143** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use and disclosure of your IIHI, you must make your request in writing to **Privacy Officer, PrimeCare Medical Clinic, 205 E Race St, Searcy, AR 72143, (501)279-9000**. Your request must describe in a clear and concise fashion:

- a) The information you wish restricted;
- b) Whether you are requesting to limit our practice's use, disclosure or both; and
- c) To whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Privacy Officer, PrimeCare Medical Clinic, 205 E Race St, Searcy, AR 72143, (501)279-9000** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. 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 to **Privacy Officer, PrimeCare Medical Clinic, 205 E Race St, Searcy, AR 72143, (501)279-9000**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit a request in writing to **Privacy Officer, PrimeCare Medical Clinic, 205 E Race St, Searcy, AR 72143, (501)279-9000**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list your request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Privacy Officer, PrimeCare Medical Clinic, (501)279-9000**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our **Privacy Officer, PrimeCare Medical Clinic, (501)279-9000**. We urge you to file your complaint with us first and give us the opportunity to address your concerns. All Complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose of your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

PRIMECARE MEDICAL CLINIC

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____, have received a copy of the
PrimeCare Medical Clinic's Notice of Privacy Practices.

Signature

Date

PLEASE RETURN THIS COMPLETED FORM TO THE RECEPTIONIST

PATIENT REGISTRATION – Please Print Clearly

PATIENT NAME First Middle Last			SEX	Date of Birth	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
HOME ADDRESS		APT. NO.	CITY	STATE	ZIP
HOME PHONE	CELL PHONE	WORK PHONE	SOCIAL SECURITY NO.	EMPLOYER	
EMERGENCY CONTACT		RELATIONSHIP	HOME PHONE	WORK PHONE	
EMERGENCY CONTACT ADDRESS			CITY	STATE	ZIP

FAMILY DOCTOR (FIRST AND LAST NAME PLEASE)	PREFERRED PHARMACY NAME	ADDRESS OF PHARMACY
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PLEASE COMPLETE THIS SECTION IF PATIENT IS A MINOR OR DEPENDENT

PARENT/GUARDIAN NAME First Middle Last			
ADDRESS (IF DIFFERENT FROM PATIENT)			
HOME PHONE	WORK PHONE	DATE OF BIRTH	SOCIAL SECURITY NO.

INSURANCE INFORMATION

PRIMARY INSURANCE	INSURANCE COMPANY NAME		ID OR POLICY NUMBER		GROUP/CODE
	DATE EFFECTIVE	INSURANCE COMPANY ADDRESS		POLICY HOLDER NAME (if other than pt)	
	POLICY HOLDER SOCIAL SECURITY	SEX	POLICY HOLDER DATE OF BIRTH	POLICY HOLDER ADDRESS	
	RELATIONSHIP TO PATIENT		HOME PHONE	WORK PHONE	
	IS THIS THROUGH EMPLOYER <input type="checkbox"/> OR INDIVIDUAL <input type="checkbox"/>	NAME OF EMPLOYER		COPAY AMOUNT	

SECONDARY INSURANCE	INSURANCE COMPANY NAME		ID OR POLICY NUMBER		GROUP/CODE
	DATE EFFECTIVE	INSURANCE COMPANY ADDRESS		POLICY HOLDER NAME (if other than pt)	
	POLICY HOLDER SOCIAL SECURITY	SEX	POLICY HOLDER DATE OF BIRTH	POLICY HOLDER ADDRESS	
	RELATIONSHIP TO PATIENT		HOME PHONE	WORK PHONE	
	IS THIS THROUGH EMPLOYER <input type="checkbox"/> OR INDIVIDUAL <input type="checkbox"/>	NAME OF EMPLOYER		COPAY AMOUNT	

PATIENT AUTHORIZATION

I hereby authorize PrimeCare Medical Clinic, to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported to PrimeCare Medical Clinic with regard to my insurance is correct. I also authorize the release of any necessary information, including medical information if requested by my insurance company. I permit a copy of this authorization to be used in such instances.

By signing below, I agree to pay all charges for services rendered by PrimeCare Medical Clinic which are not covered by my insurance coverage. If it becomes necessary for PrimeCare Medical Clinic to seek judicial action to enforce the above agreement, I agree to pay all collection fees and all attorneys' fees of PrimeCare Medical Clinic for such action.

REFERRALS

I understand that I am responsible for obtaining a valid referral form from my primary care physician if required by my insurance company.

PRE-CERTIFICATION

I understand that PrimeCare Medical Clinic will attempt to obtain a pre-certification as a courtesy for me. I understand that PrimeCare Medical Clinic is not obligated to obtain pre-certification for me and it is my responsibility to obtain or to make sure that any required pre-certification has been obtained for me prior to my procedure. I agree to advise and confirm with PrimeCare Medical Clinic that a pre-certification has been obtained for me. I understand in the event pre-certification is not obtained by me, I will be responsible for any amounts not paid, reduced or denied by my insurance company.

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

I agree to promptly pay all charges when billed for medical services rendered. As a parent or guardian, I agree legal responsibility for all charges incurred by the patient named on the previous page.

POLICY CONCERNING MEDICAL RECORDS

I hereby authorize PrimeCare Medical Clinic to release my medical information as I have directed. I understand that PrimeCare Medical Clinic does not copy records and that such record copying services are subject to a copying charge. I also understand said records must be requested at least two weeks in advance of desired receipt date. I understand that there is a \$10.00 charge for copying medical records and I understand that I will be billed by PrimeCare Medical Clinic for copying those medical records. Patients or other parties authorized by the patient to request medical records for legal issues, insurance, disability (not workman's compensation), physician change, or relocation from the area are subject to a copying charge. There will be no charge for copying records for a referral to another physician made by a PrimeCare Medical Clinic physician, or workman's compensation issues or any other situations covered by Arkansas law.

PATIENT RIGHT TO PRIVACY/CONFIDENTIALITY

PrimeCare Medical Clinic is committed to patient privacy and confidentiality. Therefore, you will be asked for your permission prior to the release of your records. Your medical information will be kept confidential to the degree required under existing law and regulation. However, from time to time we may need to contact you at home or work. If we need to contact you, may we have your permission to leave a message with regard to your care, any lab results, and appointment information, if you are unavailable or do not answer the phone?

I authorize/request PrimeCare Medical Clinic to:

leave a message at work _____ Yes _____ No

leave a message at home _____ Yes _____ No

In accordance with HIPAA guidelines, PrimeCare Medical Clinic is authorized to disclose my medical information to the following individuals:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

X _____
Patient/Parent or Guardian Signature

Date