Davis Hawley Eyecare

Office of Richard T. Hawley, O.D.
and Mitchell R. Davis, O.D.

NOTICE OF PRIVACY PRACTICES

This **Notice of Privacy Practices** describes how medical information about you may be used and disclosed and how you can access this information. Please review this *Notice* carefully.

This **Notice of Privacy Practices** serves several purposes. It describes: 1) How we may use and disclose your health information, 2) Your rights regarding your control of, and access to, your health information, 3) Our organization's legal duties regarding our use and disclosure of your health information and 4) Our practices related to protecting the privacy of all health information.

We are committed to protecting the privacy of your health information. In providing health care services, we will create and maintain records regarding you and the treatment and services that we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this *Notice* and to abide by all terms of this *Notice.* This *Notice* will be posted at all of our physical service delivery sites and will be posted on our web site, if we maintain one. We reserve the right to update this *Notice* as appropriate and to make the provision of the updated *Notice* effective for all health information that we maintain.

How We May Use and Disclose Your Health Information

The following information describes how we may use and disclose your health information. It contains some examples, but this should not be considered an exhaustive list, and some examples may not apply to your situation.

Treatment: We will use your health information to provide treatment and services to you. The health information obtained about you by our staff will be recorded in your health record and will be used to determine the best course of treatment for you. We may also disclose certain information to a pharmacist for the purpose of filling a prescription for you, to a physical therapist or occupational therapist under appropriate circumstances or to a facility or other provider should you require surgery or other medical care. Also, any staff members involved in your care will share information about you with each other, but only to the minimum extent necessary.

Payment: We will use and disclose your health information to prepare, submit and/or process bills to you and/or your insurer. We may contact your insurer to determine your eligibility for services and we may provide your insurer with information regarding your diagnosis, treatment and the services that we provide to you. The information we use on a bill may include information that identifies you, as well as your diagnosis, services performed and/or supplies and equipment furnished to you.

Health Care Operations: We will use and disclose your health information in the course of our day-to-day operations. Certain members of our staff may use your health information to assess the quality of the services that we provide to you and to conduct normal business planning activities.

Contacting You: We may use your health information to contact you in order to: 1) Remind you of a scheduled appointment, 2) Reschedule an existing appointment, 3) Talk to you about a missed appointment, 4) Inform you about potential treatment alternatives or other health- related information, 5) Talk to you about an outstanding balance owed to us and 6) Discuss other issues related to the services that we provide to you and related to seeking payment for services rendered to you.

Business Associates: In some instances, we may utilize external vendors - referred to as "Business Associates" - who will provide services to us in support of our operations. We may disclose your health information to these "Business Associates" so that they can perform the tasks for which they have been contracted. Please be aware that we require our "Business Associates" to appropriately safeguard all health information which has been disclosed to them.

Fami1y, Re1atives and Others: We may disclose your health information to family, relatives, your primary care physician and other persons identified by you, but only the health information which is directly relevant to their involvement, care and/or payment activities pertaining to you.

Notification in Case of Emergency: Our staff, using its best judgment, may use or disclose health information about you to notify or assist in notifying a family member, personal representative or another person/entity/health care provider in the case of an emergency.

Deceased Individuals: We may disclose health information that is consistent with applicable law to funeral directors, medical examiners, coroners, executors of your estate and others as allowed by law so that they may carry out their duties.

Marketing: It is our practice to send post cards to the address you provide us for the purpose of notifying you that you are due for an examination or other appointment. If you do not wish to receive such post cards please notify us in writing. We may use your health information for other "marketing" purposes, but only after obtaining your written authorization to use your health information.

Court Orders and Subpoenas: We may disclose your health information pursuant to a court order, or subpoena, pertaining to any purpose defined by statute and as ordered by a court of competent jurisdiction.

Suspected Abuse, Neg1ect or Domestic Vio1ence: We may disclose your health information as required by law if we suspect abuse, neglect or domestic violence, but only to entities authorized to receive such reports.

Licensing and Accreditation Organizations: We may disclose your health information pursuant to licensing and accreditation activities to maintain the health, safety and welfare of the people we serve and/or to promote quality outcomes.

Correctiona1 Institutions: Should you become an inmate of a correctional institution, or be placed under supervision of the juvenile or adult criminal court, we may disclose to the institution or agents thereof and probation or parole officers or their designees, health information necessary to preserve or maintain your health and the health and safety of other individuals.

Law Enforcement: We may disclose your health information for certain law enforcement purposes, as required by law.

Health oversight and Public Health Activities: We may disclose your health information to appropriate health oversight agencies and for the purpose of preventing or controlling disease, injury or disability, as required or allowed by law.

To Avert a Serious Threat to Health or Safety: We may disclose your health information, with certain exceptions, in order to avert a serious threat to the health or safety of you or others.

Disclosures Required by Law: We may disclose your health information for certain law enforcement circumstances, as required by regulation or law.

Your Privacy Rights Pertaining To Your Health Information

Although your health record remains the physical property of our organization, the information contained in our records belongs to you. You have numerous rights regarding your health information.

Written Authorization for Disc1osure of Health Information: When required by regulation, law or our internal privacy practices, we will obtain your written permission prior to disclosing your health information to persons/entities outside of our organization. This permission will be obtained using an *Authorization to Disclose Health Information* form. You have the right to refuse to sign any *Authorization* and the right to revoke a previously signed *Authorization.* Please make sure that you carefully read the *Authorization* form prior to signing it.

Confidential Communications: You have the right to request that we contact you at a certain location, or in a certain manner. As an example, you may request that we use an alternate address or telephone number to contact you. We will attempt to accommodate reasonable requests, but we are not required to do so. We have developed a form for this request. Please speak to one of our staff members if you have a question regarding this right.

Requesting Restrictions to Our Uses and Disclosures: You may request that we use or disclose your health information in a certain way related to our treatment, payment and health care operation activities. As an example, you may request that we not disclose your health information to a particular person. Please be aware that we are not required to agree to a requested restriction, but if we do agree to a request, we are bound by our agreement, except in emergency circumstances and certain other situations. We have developed a form for this request. Please speak to one of our staff members if you have a question regarding this right.

Access to Your Health Records and Obtaining Copies: You may request to review and obtain a copy of your health records. We may deny your request under limited circumstances, however, you may request a review of certain denials. If you request, and are granted, a copy of your health records we may charge you a reasonable cost-based fee. We have developed a form for this request. Please speak to one of our staff members if you have a question regarding this right.

Amendment to Your Health Records: You may request an amendment to your health information if you believe it is incorrect or incomplete. We may deny your request under certain circumstances. We have developed a form for this request. Please speak to one of our staff members if you have a question regarding this right.

Receiving a Copy of This Notice: You are entitled to receive a copy of this *Notice* at any time. To obtain a copy, please speak to one of our staff members. If we maintain a web site, we will make this *Notice* available on the web site.

Filing a Complaint: You may file a complaint with us, or with the Federal Government, if you believe that your privacy rights have been violated. Review the section below entitled *"Requesting Assistance, Asking Questions and Filing Complaints"* in order to determine how to file a complaint.

Our Duties and Responsibilities

We will not use or disclose your health information without your consent and/or authorization, except as allowed by law and as described in this *Notice.* We are required by law to maintain the privacy of your health information. We are required by law to provide you with a *Notice* outlining our legal duties and our privacy practices with respect to your health information. We are required to abide by the terms of this *Notice,* to notify you in writing if we are unable to agree to a requested restriction on the use of your health information and to accommodate reasonable requests made by you to communicate health information by alternative means or to alternative locations. We reserve the right to change our privacy practices at any time and to make the new provision effective for all protected health information that we maintain.

Requesting Assistance, Asking Questions and Filing Complaints

If you have a question, would like additional information about our privacy practices or experience a problem, you may contact our Privacy Officer, Dr. Hawley, at 376 East Penn Drive, Enola, PA 17025 or you may call 717-732-2423. If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer or with the Secretary of Health and Human Services, U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Washington, D.C. 20201, or by calling 202-619-0257 or toll-free 1-877-696-6775. You may also contact the United States Office of Civil Rights at 1-866-627-7748.

There will never be any type of retaliation for making an inquiry or for filing a complaint and you will never be asked to waive your right to make a complaint, or report a problem, as a condition of receiving services from us.

Effective: February 5, 2014

Receipt of Notice of Privacy Practices & Consent Form

Richard T. Hawley, O.D.
D/B/A Davis Hawley Eyecare
376 East Penn Drive
Enola, PA 17025-2158

Phone: (717) 732-2423 Fax: (717) 732-6780

www.davishawley.com

Patient Name
(No nicknames, PLEASE PRINT) _____

Date of Birth: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices.* Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office (or from our website).

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices.*

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices,* we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Davis Hawley Eyecare. I understand the *Notice* is also available at www.davishawley.com.

_____ _____

Signature of Patient (or Personal Representative) Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

Relationship to patient Print Name

Source of Authority to Sign for Patient: _____

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