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Eastern Wellness Center

Notice of Privacy Policies

HIPAA, The Health Insurance Portability and Accountability Act of 1996, established rights and protections for healthcare consumers and created responsibilities for healthcare providers. The HIPAA Privacy Rule of April 14, 2001 requires healthcare providers to implement administrative, technical, and physical safeguards to ensure the security of your individually identifiable health information that I collect to conduct my business. The following informs you of the implementation of these Privacy Policies. You will be asked to sign a **Patient Acknowledgement of Receipt of Privacy Polices** when you have finished reading this notice. You are entitled to a copy of this notice.

Information I Collect to Conduct My Business

On your initial visit, I ask you to sign an **Acupuncture/Bodywork Consent Form**, and complete a written **Confidential Patient Information Sheet** concerning your health history and other relevant personal data. Each time you visit the clinic for an acupuncture treatment, a written record of your session is made in your **Patient Chart.** Your chart contains results of your Verbal and Physical Assessment, Acupuncture/Bodywork Diagnosis, Acupuncture/Bodywork Treatment (including acupuncture points or adjunctive methods used), and any Recommendations or Referrals from Physicians. The Patient Chart is maintained electronically in a cloud-based Electronic Health Record (EHR) computer system. This EHR is HIPPA-compliant and encrypted for your protection. It is accessed through a password-protected device (such as a Smart Phone, a laptop, or an iPad or Tablet).

Your Privacy Is Protected

I do not share any information regarding your medical or personal history without your written authorization.

Release Of Information

If you wish to have your protected health information shared with a physician or family member, you must sign an **Authorization for Release of Health Information** with a specific indication of the information I have collected that you want released. You must indicate the length of this release. I do not share your health information with any family member without your written consent on the Authorization for Release of Health Information. I do request the right to call a family member, at the number you have provided us with for, for emergencies, should one occur while you are in my care.

Exceptions To Your Written Authorization

HIPAA explicitly allows discloser of patient health information without consent for the following situations: emergency circumstances; identification of the body of a deceased person or the cause of death; public health needs; research; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security.

Contacting You

I do request the right to call you at the phone numbers you have given us for the sole purpose of making appointments; notifying you of cancellations due to inclement weather; or to inquire about your health status between treatments. I request the right to leave messages on these numbers. If you do not want me to provide this service, please indicate such in writing on the Authorization for Release of Health Information. I request the right to mail or email you information concerning marketing materials, notice of events, or other materials to the address and email you have provided me with. If you do not want us to provide this service, please indicate such in writing on the Authorization for Release of Health Information.

Complaints

Complaints about your privacy rights or how your privacy is handled at this office can be directed to Monica Fauble, by calling her published phone number or by directing a letter to her attention. If you are not satisfied with how your complaint is handled you may submit a formal complaint to: DHHS (Office of Civil Rights), 200 Independence Avenue, SW Room 509F HHH Building Washington, DC 20201

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I, _____, have read, reviewed, understand, and agree to the statement of Privacy Policy for healthcare services in this office.

This practice has attempted to provide me with copy of Privacy Polices.

Patient Signature _____ Date _____

Witness Signature _____ Date _____