BALANCE
INTEGRATIVE HEALTH

NOTICE OF PATIENT RIGHTS AND PRIVACY PRACTICES
PROTECTED HEALTH INFORMATION (PHI) / HIPAA

Patient Name (Print) _____ Date _____

This "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations at Balance Integrative Health. This "Notice of Privacy Practices" also describes my rights, as well as the duties of the practitioner with respect to my protected health information.

My "Protected Health Information" means health information, including any demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition that identifies me, or there is a reasonable basis to believe the information may identify me.

Patient Rights

1. **Confidential Communications**: You have the right to request that our practice communicate with you about health and related issues in a particular manner or at a certain location. Our practice will accommodate reasonable request.
2. **Requesting Restrictions:** You have the right to request restriction on our use of disclosure of your PHI for treatment, payment, or health care operations. 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.
3. **Inspection and Copies:** You have the right to suspect and obtain a copy of your PHI. Our practice will charge a fee for the cost of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy limited circumstances; however you may request a review of our denial.
4. **Amendment:** You may ask us to amend 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 this practice. You request must provide us with the reason that supports your request for amendment. Your request may be denied if you ask us to amend information that is in our opinion: a) accurate and complete; b) not part of the PHI kept by or for the practice; c) not part of the PHI that 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. **Rights 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.
6. **Rights to File a Complaint:** If you believe your privacy rights have been violated you may file a complaint without practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Privacy Practices

Balance Integrative Health is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to your information we collect and maintain about you.
- Abide by the terms of this practice.
- Notify you if we are unable to agree to a requested restriction, and accommodate any reasonable request you may have to communicate health alternative means or alternative locations.
- We will not use or disclose your health information without your authorization, except as described in this notice.

- ❖ We will use and disclose your PHI in order to bill and collect payment for the services and items you may have received from us. For example, we will contact your 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, or pay for, your treatment.

WE ARE PERMITTED TO USE, AND MAY BE REQUIRED, TO DISCLOSE YOUR PHI UNDER SPECIAL CIRCUMSTANCES:

1. **Disclose Required By Law**: Our practice will use and disclose your PHI when we are required to do so by federal, state or local law, including health oversight activities, court or administrative orders or similar legal proceedings.
2. **Public Health Risk:** Our practice may disclose your PHI to public health authorities who are authorized to collect information for such purposes as maintaining vital records, preventing or controlling disease, injury, or disability; or notifying a person regarding potential exposure to communicable diseases.
3. **Serious Threats to Health of Safety:** Our practice may disclose your PHI 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.
4. **Deceased Patients:** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
5. **Organ Donor:** Our practice may release PHI to a medical facility for tissue procurement of transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
6. **Worker's Compensation:** Our practice may release your PHI for workers' compensation and similar programs.

Our practice may contact you or your authorized representatives to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The practice will routinely contact patients via telephone at home and/or work, via mail at home, and unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments and billing questions.

I consent to the use or disclosure of my protected health information by Balance Integrative Health for the purpose of analyzing, diagnosing or providing treatment; as well as obtaining payment for my health care bills or to conduct health care operations. I understand that analysis and treatment by Balance Integrative Health may be conditioned upon my consent as evidenced by my signature below. I understand the clinical and administrative staff may review my patient records and lab reports but all my records will be kept confidential and will not be released without my written consent.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Balance Integrative Health is not required to agree to the restrictions that I may request. However, if Balance Integrative Health agrees to a restriction that I request, the restriction is binding on Balance Integrative Health.

Patient's Name (please print) _____

_____ _____

Signature of patient or legal guardian **Date**

If you have any question regarding this notice or would like to exercise any of your rights under this notice, you may contact:

Privacy Officer
Balance Integrative Health
2121 Magazine Street
New Orleans, LA 70130
504-522-9645