CENTER OF SURGICAL SPECIALISTS, P.C.
Notice of Privacy Practices for Protected Health Information
Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

USES AND DISCLOSURE OF HEALTH INFORMATION

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Some examples of uses or disclosure of your health information for these purposes are:

- Sharing notes and reports or test/pathology results with other health care providers for ongoing treatment of your condition or referral to another physician.
- Obtaining information about you which is recorded in your health record.
- Providing your diagnosis and/or other information about your health to your insurance company to obtain payment for the health care services we provide.
- To obtain services from our insurers or other business associates such as quality assessment, quality improvement, training programs, credentialing, medical review, legal services, accounting services and insurance.

OTHER USES AND DISCLOSURES

The office may create and distribute de-identified health information by removing all references to individually identifiable information. The office may also use or disclose your protected health information, in compliance with guidelines outlined by law, for the following purposes:

- Providing you with information related to your health;
- Contacting you regarding appointments, information about treatment, or other health related services;
- Incidental uses or disclosures (e.g., listing your name on a sign-in sheet, etc.);
- Informing a family member, other relative, or close personal friend when:

  - Information is relevant to the individual's involvement with your care;
  - To notify of your location, general condition or death;
  - To assist in your health care (e.g., pick up prescriptions or other documents, note follow up care instruction, etc.).
- Compliance with all laws, (including reports of suspected abuse, neglect or violence);
- Providing information to a coroner, medical examiner, funeral director, or organ procurement organization;
- Providing certain specified information to law enforcement or correctional institutions;
- Responding to court or administrative tribunal orders, subpoenas, discovery request or other lawful process;
- Public health activities when requested by a public health authority or the FDA;
- Responding to health oversight agencies;
- Research activities;
- When necessary to avert a serious threat to health or safety;
- Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities; or
- Providing information regarding your location, general condition or death to public or private disaster relief agencies.

Any other uses or disclosures will be made only with your written authorization which may be revoked at any time.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

- Request restrictions on certain uses and disclosures of your health information by delivering the request to our office. However, we are not required to grant the request;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health and billing record with some limited exceptions – you may exercise this right by delivering a written request to our office. Please be advised there is a charge to inspect and copy your records. This request will be granted within thirty (30) days for on-site records and sixty (60) days for all records located outside our office. An extension of no more than thirty (30) days is allowed if we provide you with a written notice of the reason for the delay as well as the date we will complete your request;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information. You must submit this request in writing to our office and provide the reason(s) supporting the requested amendment. We may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for the office;
- Is not part of the information that you would be permitted to inspect and copy; or,
- Is accurate and complete.

Demographic information (e.g.: name, address, phone number, etc.) may be changed as opposed to being formally amended.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a written statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact Crystal Keefer, Privacy Officer, 9351 Grant St, Suite 400, Thornton, CO 80229, 303-452-0059, in person or in writing, during regular, business hours. She will inform you of the steps that need to be taken to exercise your rights.

OUR RESPONSIBILITIES

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Crystal Keefer, Privacy Officer, at 303-452-0059.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Crystal Keefer, Privacy Officer, Center of Surgical Specialists, 9351 Grant St, Suite 400, Thornton, CO 80229. You may also file a complaint to the Secretary of Health and Human Services, Office of Civil Rights, 200 Independence Ave, SW, Washington, D.C. 20201.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Center of Surgical Specialists, P.C.
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Name of Patient (please print) **Date of Birth**

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received Center of Surgical Specialists, P.C.'s Notice of Privacy Practices.

Signature of patient or patient representative Date

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For office use only

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on _____ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

☐ Patient refused to sign.

☐ Patient was unable to sign or initial because:
_____
_____

☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

☐ Other reason (describe below):
_____
_____

Signature of Employee Completing Form Date

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PATIENT HIPAA QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

_____

_____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name _____ Phone_____

Name _____ Phone_____

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

_____

_____

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES _____ NO_____

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:
( )_____

*** I am fully aware that a cell phone is not a secure and private line.**

**** I am fully aware my health information can be transmitted by facsimile (fax), mail or the internet.**

VI. Can confidential messages (i.e., appointment reminders) be left on your answering machine or voicemail?

YES_____ NO _____

PATIENT NAME_____

PATIENT/GUARDIAN SIGNATURE_____

DATE _____