



The Beauty of Transformation

## Plastic Surgical Arts

### Notice of Privacy Practices

#### Effective 11/01/2021

The privacy of your protected health information (PHI) is extremely important to us. We want you to understand how we use and disclose your information and your rights regarding your PHI. This Notice of Privacy Practices describes our legal duties with respect to your health care information.

#### **How we may use and disclose health care information about you:**

**For Care or Treatment:** Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. Your authorization is required to disclose PHI to any other care provider not currently involved in your care.

**For Payment:** Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment.

**For Healthcare Operations:** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment and improvement activities, reviewing the quality of care provided by your health care providers, training of personnel and medical students, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results.

**Required by Law:** Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

**Without Authorization:** Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Verbal Permission:** We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

**With Authorization:** Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

### **Your rights regarding your PHI**

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

### **Website Privacy**

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable

to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

**Breaches:**

You will be notified immediately if we receive information that there has been a breach involving your PHI.

**Complaints:**

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at *Plastic Surgical Arts*. If you have questions and would like additional information, you may contact us at 402-483-2572.

Please sign below to indicate that you have received and read our Notice of Privacy Practices. If you have questions, please speak to your physician or our information privacy officer.

## Acknowledgment of Privacy Practices

I, \_\_\_\_\_, have received a copy of Plastic Surgical  
(print patient name)

Arts Notice of Privacy Practices.

*(The portion below is optional. Fill out only if you want others to be able to obtain/discuss your medical records)*

I, \_\_\_\_\_, give permission to the following person(s) to obtain or discuss any/all of my medical information.

Name: \_\_\_\_\_, Relationship: \_\_\_\_\_

Name: \_\_\_\_\_, Relationship: \_\_\_\_\_

Name: \_\_\_\_\_, Relationship: \_\_\_\_\_

Name: \_\_\_\_\_, Relationship: \_\_\_\_\_

Yes, I am giving permission to the individuals listed above to discuss and/or obtain protected health information about myself/patient and I understand that I may revoke this permission in writing at any time.

No, I do not want to give anyone permission to discuss or obtain protected health information other than the physicians and medical facilities involved in my care.

\_\_\_\_\_  
Patient/Guardian Printed Name

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Today's Date