ADVANCED
WOUND CARE

HIPAA – Notice of Privacy Practices

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
Your protected health information may be used and disclosed by your healthcare provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a healthcare provider to whom you have been referred to ensure that he/she has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information may be used to bill or obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for your services, such as making a determination of eligibility or coverage for insurance benefits and reviewing services provided to you for medical necessity.

HEALTHCARE OPERATIONS: We may use or disclose, as-needed, your protected health information in order to support our business activities. These activities include, but are not to, quality assessment, employee review, training of staff, licensing, and conducting or arranging for other business activities. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION
We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law,

communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. You may revoke the authorization, at any time, in writing, except to the extent that your healthcare provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

- **You have the right to inspect and copy your protected health information** – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to your or to another person, or information that was obtained under a promise of confidentiality.

- **You have the right to request a restriction of your protected health information** – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your healthcare provider is not required to agree to your requested restriction except if you request that the not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

- **You have the right to receive an accounting of certain disclosures** – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment and healthcare operations.

- **You have the right to receive notice of a breach** – We will notify you if your unsecured protected health information has been breached.

- **You have the right to obtain a paper copy of this notice.** We reserve the right to change the terms of this notice and will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS: You may report a complaint to us if you believe your privacy rights have been violated by us. You may file a complaint by notifying our Compliance Officer at clinical@awc-services.com - We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you are not satisfied with the manner in which a complaint is handled you may submit a formal complaint to the U.S. Department of Health and Human Services, Office for Civil Rights by emailing OCRComplaint@hhs.gov, visiting www.hhs.gov/ocr/privacy/hipaa/complaints/, or sending a letter to:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in the treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and healthcare provider certifications.

I understand that I may request in writing that Advanced Wound Care Services LLC restrict how my private information is used or disclosed to carry out treatment, payment or healthcare procedures. I also understand that Advanced Wound Care Services LLC is not required to agree to my requested restrictions, but if agreed, is bound to abide by such restrictions.

ACKNOWLEDGMENT

I have received, read and understand Advanced Wound Care Services LLC's Notice of Privacy Practices containing more complete description of the uses and disclosures of my health information. I understand

that Advanced Wound Care Services LLC has the right to change its Notice of Privacy Practices from time to time and I may contact at any time during normal business hours and obtain a current copy of the Notice of Privacy Practices.

_____

Patient Name (printed)

Relationship to patient (if other than patient): _____

Signature: _____ Date: _____

OFFICE USE ONLY

Advanced Wound Care Services LLC attempted to obtain the patient's signature in acknowledgement of this HIPAA Notice of Privacy Practices, but was unable to do so as documented below:

Date: _____ /_____ /_____	Staff Initials: _____