Stone Wellness – Dr. Susan Stone, DOM, AP

Understanding Your Health Record/Information

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, often referred to as your health or medical record, serves as:
•A basis for planning my care and treatments
•A means of communication among the many health professionals who contribute to my care.
•A source of information for applying my TCM diagnosis to my bill
•A means by which a third-party payer can verify that services billed were provided
•A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Understanding what is in your record and how your health information is used helps to:
•Ensure its accuracy
•Better understand who, what when, where and why others may access your health information
•Make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:
•Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
•Obtain a paper copy of the notice of information practices upon request
•Request a copy of your health record as provided for in 45 CFR 164.524 (minimal fee for services requested)
•Request an amendment to your health record as provided in 45 CFR 164.528
•Obtain an accounting disclosure of your health information by alternative means, ie request records to be mailed instead of faxed.
•Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities: This organization is required to:
•Maintain the privacy of your health information
•Provide you with a notice as to your legal duties and privacy practices with respect to information we collect and maintain about you
•Abide by the terms of this notice
•Notify you if we are unable to agree to the request restriction
•Accommodate reasonable requests you may have to communicate health information by alternative means.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us. We will not use or disclose our health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you have any questions, you may contact the office manager at Stone Wellness. If you believe that your privacy rights have been violated, you can file a complaint with the office manager or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint. Telephone : 202-619-0257 or Toll Free: 1-877-696-6775 or write to: The US Dept of Health and Human Services 200 Independence Avenue, SW Washington, DC 20201

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Examples of Disclosure for Treatment, Payment and Health Operations

We will use your health information for treatment:

For example: Information obtained by the nurse, physician, or other of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectation of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In doing this the physician will know how you are responding to treatment. We will also provide your physician or subsequent healthcare provider with copies of various reports that should assist him/her with your ongoing medical treatment.

We will use your health information for payment:

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations:

For Example: Members of the medical and/or managerial staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used to continually improve the quality and effectiveness of the healthcare and service we provide.

Communication with Family: Health professionals, using their best judgment, may disclose to a spouse or other family member you identify, health information relevant to that person's involvement in our care or payment related to your care.

Public Health: As required by law, we may disclose your health information to the public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinic standards and are potentially endangering one or more patients, workers or the public.

Effective date: April 1, 2003

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Consent for Communication and/or Disclosure

1. May our Patient Care Coordinator Contact You:

At home? Yes_____ No_____ If yes, may we leave the following information on your voice mail?
Appointment information? Yes_____No_____ Billing information Yes____ No____ Medical Information Yes____No_____

At work? Yes_____ No_____ If yes, may we leave the following information on your voice mail?
Appointment information? Yes_____No_____ Billing information Yes____ No____ Medical Information Yes____No_____

2. Please indicate the number you wish us to use to contact you:

Home_____ Work_____ Cell_____

3. Please print the names of 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 operation).:

_____ _____
Name Phone

_____ _____
Name Phone

_____ _____
Name Phone

4. Please list family members or significant others, if any, whom we may inform about your medical condition ONLY IN CASE OF EMERGENCY:

_____ _____ _____ _____
Name Phone Name Phone

5. Please print the address where you wish billing statements and/or correspondence to be sent if other than to your home.

_____ _____ _____ _____
Street City State Zip

6. Do you require that all correspondence from our office be marked "CONFIDENTIAL"? YES_____ NO_____

7. May we send you email messages, such as newsletters and Stone Wellness updates events and specials? YES___ NO____

If yes, please provide your email address:_____

I request the above alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Stone Wellness and give my permission to share the information as indicated with the person(s) named above.

_____ _____ _____
Patient Name (print) Patient Signature Date