SURGICAL ASSOCIATES

2448 E 81st, STE 1100
TULSA, OK 74137
918-505-3400

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

THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 "HIPPA" IS A FEDERAL PROGRAM THAT REQUIRES THAT ALL MEDICAL RECORDS AND OTHER INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION USED OR DISCLOSED BY US IN ANY FORM, WHETHER ELECTRONICALLY, ON PAPER, OR ORALLY, ARE KEPT PROPERLY CONFIDENTIAL. THIS ACT GIVES YOU, THE PATIENT, SIGNIFICANT NEW RIGHTS TO UNDERSTAND AND CONTROL HOW YOUR HEALTH INFORMATION IS USED. HIPPA PROVIDES PENALTIES FOR COVERED ENTITIES THAT MISUSE PERSONAL HEALTH INFORMATION.

AS REQUIRED BY HIPPA, WE HAVE PREPARED THIS EXPLANATION OF HOW WE ARE REQUIRED TO MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION AND HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION.

WE MAY USE AND DISCLOSE YOUR MEDICAL RECORDS ONLY FOR EACH OF THE FOLLOWING PURPOSES: TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

- TREATMENT MEANS PROVIDING, COORDINATING OR MANAGING HEALTH CARE AND RELATED SERVICES BY ONE OR MORE HEALTH CARE PROVIDERS.

- PAYMENT MEANS SUCH ACTIVITIES AS OBTAINING REIMBURSEMENT FOR SERVICES, CONFIRMING COVERAGE, BILLING OR COLLECTION ACTIVITIES, AND UTILIZATION REVIEW. AN EXAMPLE OF THIS WOULD BE SENDING A BILL FOR YOUR VISIT TO YOUR INSURANCE COMPANY FOR PAYMENT.

- HEALTH CARE OPERATIONS INCLUDE THE BUSINESS ASPECTS OF RUNNING OUR PRACTICE, SUCH AS CONDUCTING QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES, AUDITING FUNCTIONS, COST-MANAGEMENT ANALYSIS AND CUSTOMER SERVICE. AN EXAMPLE WOULD BE AN INTERNAL QUALITY ASSESSMENT REVIEW.

WE MAY ALSO CREATE AND DISTRIBUTE DE-IDENTIFIED HEALTH INFORMATION BY REMOVING ALL REFERENCES TO INDIVIDUALLY IDENTIFIABLE INFORMATION.

WE MAY CONTACT YOU TO PROVIDE APPOINTMENT REMINDERS OR INFORMATION ABOUT TREATMENT ALTERNATIVES OR OTHER HEALTH-RELATED BENEFITS AND SERVICES THAT MAY BE OF INTEREST TO YOU.

ANY OTHER USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOU MAY REVOKE SUCH AUTHORIZATION IN WRITING AND WE ARE REQUIRED TO HONOR AND ABIDE BY THAT WRITTEN REQUEST, EXCEPT TO THE EXTENT THAT WE HAVE ALREADY TAKEN ACTIONS RELYING ON YOUR AUTHORIZATION.

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION, WHICH YOU CAN EXERCISE BY PRESENTING A WRITTEN REQUEST TO THE PRIVACY OFFICER.

- THE RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION, INCLUDING THOSE RELATED TO DISCLOSURES TO FAMILY MEMBERS, OTHER RELATIVES, CLOSE PERSONAL FRIENDS, OR ANY OTHER PERSON IDENTIFIED BY YOU. WE ARE, HOWEVER, NOT REQUIRED TO AGREE TO A REQUESTED RESTRICTION. IF WE DO AGREE TO A RESTRICTION, WE MUST ABIDE BY IT UNLESS YOU AGREE IN WRITING TO REMOVE IT.
- THE RIGHT TO REASONABLE REQUESTS TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION FROM US BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATIONS.
- THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION.
- THE RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION.
- THE RIGHT TO BE NOTIFIED UPON A BREACH OF ANY OF YOUR UNSECURED PROTECTED HEALTH INFORMATION.
- THE RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION.
- THE RIGHT TO OBTAIN A PAPER / ELECTRONIC COPY OF THIS NOTICE FROM US UPON REQUEST.

OUT-OF-POCKET-PAYMENTS:
IF YOU PAID OUT-OF-POCKET (OR IN OTHER WORDS, YOU HAVE REQUESTED THAT WE NOT BILL YOUR HEALTH PLAN) IN FULL FOR A SPECIFIC ITEM OR SERVICE, YOU HAVE THE RIGHT TO ASK THAT YOUR PROTECTED HEALTH INFORMATION WITH RESPECT TO THAT ITEM OR SERVICE NOT BE DISCLOSED TO A HEALTH PLAN FOR PURPOSES OF PAYMENT OR HEALTH CARE OPERATIONS, AND WE WILL HONOR THAT REQUEST.

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION AND TO PROVIDE YOU WITH NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION.

THIS NOTICE IS EFFECTIVE AS OF APRIL 14, 2003 AND WE ARE REQUIRED TO ABIDE BY THE TERMS OF THE NOTICE OF PRIVACY PRACTICES CURRENTLY IN EFFECT. WE RESERVE THE RIGHT TO CHANGE THE TERMS OF OUR NOTICE OF PRIVACY PRACTICES AND TO MAKE THE NEW NOTICE PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH THAT WE MAINTAIN. WE WILL POST AND YOU MAY REQUEST A WRITTEN COPY OF A REVISED NOTICE OF PRIVACY PRACTICES FROM THIS OFFICE.

YOU HAVE RECOURSE IF YOU FEEL THAT YOUR PRIVACY PROTECTIONS HAVE BEEN VIOLATED. YOU HAVE THE RIGHT TO FILE A WRITTEN COMPLAINT WITH US AT THE ADDRESS BELOW, OR WITH THE DEPARTMENT OF HEALTH & HUMAN SERVICES, OFFICE OF CIVIL RIGHTS, ABOUT VIOLATIONS OF THE PROVISIONS OF THIS NOTICE OR THE POLICIES AND PROCEDURES OF OUR OFFICE. WE WILL PROVIDE YOU WITH THE ADDRESS TO FILE YOUR COMPLAINT WITH THE U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES UPON REQUEST. WE SUPPORT YOUR RIGHT TO THE PRIVACY OF YOUR HEALTH INFORMATION. WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

By Oklahoma law, we are required to notify you ... **that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

PLEASE CONTACT US FOR MORE INFORMATION

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ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices.

_____ _____
Patient Name (Please Print) Date

_____
Parent or Authorized Representative (If applicable)

_____
Signature

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I, _____(patient) _____(date of birth)
hereby give Surgical Associates, Inc. permission to discuss my medical and/or billing information with the following person/persons:

_____

_____

Either by oral communication or written communication,
whichever is appropriate at the time.

I, _____(patient) _____(date of birth)
hereby give Surgical Associates, Inc. permission to leave messages on my voice mail____, e-mail____ or cell phone_____.

_____ _____
Patient Signature Date

Privacy Practice:
_____Individual Refused to Sign
_____Communication Barriers Prohibited Obtaining the Acknowledgment
_____ An Emergency Situation Prevented Us from Obtaining Acknowledgment
_____ Other