NOTICE OF PRIVACY PRACTICES

INTEGRATED MEDICINE ALLIANCE

P.O. Box 8519
Red Bank, NJ, 07701
Telephone: (732) 460-9840

PURPOSE:

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

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information (IIHI). This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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 (PHI) 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. At all IMA offices, the privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. Our practice will also post a copy in our office in a visible location at all times.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

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 a plan for future care or treatment. This information, often referred to as your health or medical record, serves as :

- a basis for planning your care and treatment
- a means of communication among the many health professionals who contribute to your care
- a legal document describing the care you received
- the means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you 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
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

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Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

RIGHT TO INSPECT AND COPY

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. To inspect and copy medical information that may be used to make decisions about you, you must contact the office to obtain the "Right to Inspect Form". Once you have received this form, please fill it out thoroughly and send the form back to the office.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed.

RIGHT TO REQUEST RESTRICTIONS

You may 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 this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting the office for a "Request of Restrictions Form". This form must be submitted to our office.

RIGHT TO AMEND

This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to obtain the "Health Record Amendment Form". This form must be submitted to our office.

RIGHT TO RECEIVE CERTAIN ACCOUNTING DISCOSURES

This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. Please contact our Privacy Contact to obtain the "Request for Accounting Disclosures Form". This form must be submitted to our office.

RIGHT TO OBTAIN A PAPER COPY

You are entitled to receive a paper copy of our notice of privacy practices. To obtain a paper copy of this notice, please contact the Office.

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OUR RESPONSIBILITIES

Integrated Medicine Alliance is required to:

- maintain the privacy of your health information
- provide you with a notice as to our 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 a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

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've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

COMPLAINTS

If have questions and would like additional information, you may contact Integrated Medicine Alliance's Privacy Officer at 732-460-9840.

If you believe your privacy rights have been violated, you can file a complaint with Integrated Medicine Alliance's Privacy Officer or with the secretary of Health and Human Services. Please contact the office to obtain the "Complaint Form". This form must be submitted to our office. There will be no retaliation for filing a complaint.

HOW WE MAY USE AND DISCLOSE YOUR TREATMENT INFORMATION

For example: Information obtained by a nurse, physician, or other member 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 expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

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.

HEALTHCARE OPERATIONS

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team 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 in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

BUSINESS ASSOCIATES

There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

APPOINTMENT REMINDERS

We may contact you by phone or leave a message on your home, work or cell phone as a reminder that you have an appointment scheduled for medical care at the office. Please notify us if you do not wish to be contacted for appointment reminders.

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NOTIFICATION

We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

COMMUNICATION WITH FAMILY MEMBERS

Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

RESEARCH

We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

DISCLOSURES REQUIRED BY LAW

We may use or disclose your protected health information to the extent that the use or disclosure is required by federal, state, or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

MILITARY AND NATIONAL SECURITY:

When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (l) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

WORKERS' COMPENSATION/HEALTH OVERSIGHT ACTIVITIES:

Your Protected Health Information may be disclosed by us as authorized to comply with Workers' Compensation laws and other similar legally established programs.

We may disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

LAWSUITS AND DISPUTES:

If you are involved in a lawsuit or a dispute, we may disclose your medical information in response to a court or administrative order. We may also disclose your medical information in response to a subpoena.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS:

We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION:

We will not use or disclose your Protected Health Information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization in writing at any time. If you revoke the Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. We cannot release you're your Psychotherapy Notes without a special signed, written authorization (different than the Authorization mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have a special written authorization that complies with the law.

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FOOD AND DRUG ADMINISTRATION (FDA)

We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

CORRECTIONAL INSTITUTION

Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

This notice was published and becomes effective on January 20, 2003.

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

PATIENT NAME: _____ DOB: _____

I designate the following person(s) listed below to correspond and receive my protected health information. I understand that I am not required to list anyone other than myself unless I choose to. I also understand that I may request to change this list at any time in writing.

Name: _____ Relationship _____ Phone Number _____

Name: _____ Relationship _____ Phone Number _____

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (PLEASE CHECK ALL THAT APPLY)

Primary Phone Number _____ Home Cell or Work

Secondary Phone Number _____ Home Cell or Work

OK to leave messages including personal medical information? ◯ YES ◯ NO

OK to leave messages asking you to call us back? ◯ YES ◯ NO

OK to send on Patient Portal? ◯ YES ◯ NO E-Mail Address _____

_____ _____

SIGNATURE OF PATIENT DATE

_____ NAME _____ RELATIONSHIP_____

(IF UNDER 18 PARENT OR GUARDIAN SIGNATURE, NAME AND RELATIONSHIP)

I ACKNOWLEDGE I HAVE READ THE NOTICE OF PRIVACY PRACTICES.