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NOTICE OF INFORMATION PRACTICES

Effective April 14, 2003. This notice describes how medical information about you may be used and disclosed and haw you can get access to this information. Please review this information carefully.

Patient Privacy

At Westborough Podiatry, your privacy is a priority. We follow strict federal and state guidelines to maintain the confidentiality of your medical (protected health) information.

Protected Health Information

Protected Health Information (PHI) is any information about your past, present, or future health care, or payment for that care which could be used to identify you. Members of our workforce and our business associates may only access the minimum amount of protected information that they need to complete their assigned tasks.

Use and Disclosure of PHI

When you visit Westborough podiatry, we use and disclose your protected health information to treat you, to obtain payment for services, and to conduct normal business known as health care operations. We may also share information with a contracted business associate who must meet our privacy requirements. Examples of how we use your information include:

Treatment: We document each visit and/or admission. This documentation may include your test results, diagnoses, and medication; and also your response to medications or other therapies. This allows your doctors, nurses and other clinical staff to provide the best care to meet your needs.

Payment: We document the services and supplies you receive at each visit so that you, your insurance company, or other third party can pay us. We may tell your health plan about upcoming treatments or services that require preapproval.

Health Care Operations: Medical information is used to improve the services we provide, to train staff and students, and for business management, performance improvement and customer service.

We may also use information to:

Recommend treatment alternatives

Tell you about health benefits and services

Communicate with other members or business associates for treatment or payment

Provide appointment reminders

There are limited times when we are permitted or required to disclose medical information without your signed permission. These situations include the following:

For public health activities such as tracking diseases or medical devices

To protect victims of abuse or neglect

For federal and state health oversight activities such as fraud investigations

For judicial or administrative proceedings

If required by law or law enforcement

To coroners, medical examiners, and funeral directors

For organ donation

To avert serious threat to public safety

For specialized government functions such as national security

To workers compensation if you are injured at work

To a correctional institute if you are an inmate

For research following strict review to ensure protection of information

Other uses and disclosures not previously described may only be done with your signed authorization. You may revoke your authorization, in writing at any time.

OUR RESPONSIBILITIES

Westborough Podiatry is required by law to maintain the privacy of your medical information, provide this notice of our duties and privacy practices, and abide by the terms of the notice currently in effect.

We reserve the right to change privacy practices effective for all the information we maintain. Revised notices will be posted in our facility and will be available from your healthcare provider.

YOUR RIGHTS

You have the right to:

Request that we restrict how we disclose your medical information

Request that we use a specific telephone number or address to communicate with you

Inspect and copy your medical information

Receive an accounting of how your medical information was disclosed (excludes disclosure for treatment, payment, healthcare operations, and some required disclosure; fees may apply)

Obtain a paper copy of this notice even if you receive it electronically

Register a complaint

WESTBOROUGH PODIATRY LLC

Acknowledgement of Receipt

Notice of Information Practices

Please print your (patient) name and sign below

I ***(Print Patient Name),*** _____

hereby acknowledge that I have received a copy of the Westborough Podiatry Joint Notice of Information Practices (the notice).

I understand that the notice describes how our office uses and discloses my medical and billing information. The notice also describes my rights and how I can receive additional information.

Signature of Patient/Legal Guardian_____ Date_____

Relationship to Patient_____

FOR OFFICE USE ONLY

SCANNED ☐

Acknowledgement obtained by: Date