



Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed. The practice has implemented policies and procedures so that the confidentiality of your personal and medical information remains confidential.

So that we may provide you or your dependent with appropriate medical care, for general practice operations and/or for the purpose of obtaining payment, we will, at our discretion, provide information regarding the treatment you or your dependent received in this practice, the charges for this treatment and related information regarding the treatment and charges to other health related entities such as; Physician/Non-Physician Providers who work outside of this practice, Medical Facilities, Laboratories for the purposes of running medical tests, other health care providers such as pharmacies, durable equipment suppliers, and ambulance services, insurance companies (or third party administrators) for the purpose of obtaining payments, reviewing medical necessity and/or general case management, State or Federal agencies that require the submission of specific health related information. This information will be submitted by means of the U.S. Postal Service, fax, Internet, voicemail, and/or personal communications.

We may need to contact you by telephone to discuss your appointments, test results, treatment, referrals, an account balance, and/or to return your phone call. We will first attempt to contact you on your cell phone; however, if you are not available and you provide us with a work or home phone number, we may attempt to contact you on those numbers

In the event that you do not pay all of your charges at the time of your visit, we will mail a statement to your home. We may mail other correspondences to your home noting that we are trying to contact you regarding and appointment, test result information and/or information that you may have requested, or information regarding your account in order to collect a debt. We may contact your insurance company to determine your coverage, eligibility, unmet deductible and/or your co-insurance and co-pay requirement.

If you would like information sent to another physician or medical facility, you must sign an authorization to release your information. We will provide this form for you. You may have to fill out a separate form to have your records and documentation send to us from another facility.

You have the right to inspect and copy your protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. This may not include psychotherapy notes. You must submit your request in writing to the Practice Manager in order to inspect and/or obtain a copy of your PHI. Requests for PHI will be processed and completed within 30days; if an extension is needed to process the documents it will not exceed an additional 30 days. Our practice may charge a fee for the costs of emailing encrypted PHI, use of a USB memory stick, CD, copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of any denial. Another licensed health care professional chosen by us will conduct reviews.

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 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 the procedures have been submitted to your insurance company. At your request the physician may not disclose information about care that you have paid for out-of-pocket, unless for treatment purposes or in the rare event disclosure is required by law. If your 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, unless it is for information you have paid out-of-pocket for. If your physician agrees 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. You may request a restriction by providing a written request to the practice at any time. Your physician is also not allowed to sell any of your PHI without your written authorization. Breach Notification: We will notify you if there has been a breach of your PHI.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, for example, if we think the information is correct, or was not created by our practice, 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 Practice Manager to determine if you have questions about amending your medical record. To file an amendment, your request must be in writing and must be submitted to the Practice Manager.

When necessary, these policies will be modified to ensure compliance with the practice operations and with State and Federal privacy regulations. If you have any questions or concerns with the policies and/or procedures noted above, please contact the Practice Manager to discuss them. We trust that you are comfortable with our efforts to maintain confidentiality or the information related to you or your dependent's medical care.

I have read & understand the Privacy Policies (HIPPA) for Sullivan Integrated Aesthetic Center.

Patient Signature _____ **Date:** _____

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