Richard P Chern, MD LLC

Concierge and Aesthetics

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.

Each time you visit a physician, hospital, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. Your record represents Protected Health Information.

We are committed to treating and using Protected Health Information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This Notice applies to all Protected Health Information, as defined by federal regulations, which is generated by our office.

THE FOLLOWING CATEGORIES DESCRIBE EXAMPLES OF THE WAYS WE USE AND DISCLOSE HEALTH INFORMATION
For Treatment: We may use your health information to provide you with medical treatment or services. We may disclose medical information about you to other health professionals who contribute to your care (such as doctors, nurses, technicians, or other personnel who are involved in taking care of you).

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your treatment so they will pay us for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it, unless you exercise your right to restrict**

For Healthcare Operations (Business Associates): There are some services provided in our office through contracts with business associates. Examples include e-Prescribing service, a person who provides data transmission services, computer software vendor, and subcontractors that create, receive, maintain or transmit your medical information on behalf of the contracted Business Associate as required by Omnibus HIPAA Rule compliance. When services such as these are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information as required by HIPAA regulations.

Communication with Family or Friend: We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

For Research, Marketing, and Fundraising: Our office does not sell your protected health information. Any activity for marketing, fundraising requires your written authorization.

We may also use and disclose medical information to/for the following:

* To remind you that you have an appointment
* To assess your satisfaction with our services
* Food and Drug Administration

* Organ and Tissue Donation Organizations
* Health Oversight Agencies
* Funeral Directors, Coroners, Medical Directors
* Protective Services for the President of the United States
* To notify or assist in notifying a disaster relief entity so that your family can be notified about your health status

* For law enforcement purposes as required by law or in response to subpoena

YOUR HEALTH INFORMATION RIGHTS Although your health record is the physical property of this office, you have the right to:

Inspect and Copy: You have the right to view your Protected Health Information, obtain a copy of the information, or both. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We are allowed to charge you for these copies. If capabilities exist, you may request access to your medical records in electronic format.

Amend: If you feel that medical information is incorrect or incomplete, you may ask us to amend (not change) the information. We may deny your request for an amendment; and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request a list of certain disclosures we make of your medical information for purposes other than treatment, payment, or healthcare operations.

* Public Health Authorities
* Workers Compensation Agents * Legal Authorities
* Military Command Authorities * National Security & Intelligence

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree to the requested restriction, it will be honored with the exception of permitted disclosures, including emergency treatment, public health authority, Food & Drug Administration, work-related injury, and OSHA compliance.

**Restricted Disclosure: You have the right to restrict disclosure of your personal protected health information to your health plan/insurance company if that information pertains solely to healthcare for which you (or a person on your behalf) paid for the testing or treatment in full, out of pocket. You must continue to pay out of pocket for subsequent care related to restricted disclosure.

Genetic Information: Your genetic information is treated as Protected Health Information. It cannot be used to discriminate against you for the provision of health insurance or for underwriting purposes.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location (for example, at work, email or by U.S. Mail). We will grant this request only if it is submitted in writing. We reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.

Breach: You will be notified within sixty days if a reportable breach of your protected health information occurs. A Paper Copy of This Notice: You may ask us to give you a copy of this Notice.

If you have any questions about this Notice, please contact our Privacy Officer at this office, 850.837.1271
*We reserve the right to change this notice and to make the new provisions effective for all Protected Health Information we maintain from the first date of your health record. The current notice will be posted and include the effective date.
*If you believe your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer in our office. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
*You may revoke your permission to use or disclose medical information about you, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Updated Notice of Privacy Practices 7-23-2015
Original Effective Date 06/02/2007

Acknowledgment of Receipt of Notice of Privacy Practices - Office of Richard P Chern, MD LLC By signing this document, I acknowledge that I have read a copy of this office's Notice of Privacy Practices.

_____ (Initial) I would like the following restrictions regarding the use and disclosure of my health information:

FAMILY MEMBERS / SIGNIFICATION
Please list family members or other persons, if any, whom we may inform about your appointments, insurance & payment information and medical condition; including treatment, test results. Please list names & their relationship to you.

I consent to medical treatment by Richard P Chern, MD LLC and understand my rights as outlined in the Notice of Privacy Policies and Practices. I hereby acknowledge that I have received, reviewed and understand the contents of Richard P Chern, MD LLC Patient's Office Policy Guide. I have had an opportunity to ask any questions regarding the guide and understand that I can ask questions at any time I require clarification.

_____ _____ Printed Patient Name
Patient/Parent/Guardian Signature

_____
Date (This consent is effective for 6 years from this date)