

## Light Touch Physical Therapy

### 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.**

This Notice applies to Light Touch Physical Therapy and describes certain privacy practices of Light Touch Physical Therapy. We are committed to ensuring the privacy and security of patient health information, and will ensure any use or disclosure of protected health information is in compliance with all applicable federal, state and/or local laws and regulations. Your health information is contained in a medical record that is the physical property of Light Touch Physical Therapy.

**Light Touch Physical Therapy has the right to use and disclose health information for your treatment, to bill for the treatment and services you receive, and to operate our business. We may use or disclose your health information, without your consent, in the following ways:**

**For Treatment:** We may use your health information to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other personnel who are involved in your care and treatment at our facility. We may also disclose medical information about you to people outside our facility who may be involved in your medical care, such as other physicians, family members you designate, or other health care related entities with whom you seek treatment.

**For Payment:** We may use and disclose your health information to others for purposes of receiving payment for treatment and services you receive. A bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

**Appointments:** We may use and disclose your health information to contact you as a reminder that you have an appointment at our facility.

**WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION FOR THE FOLLOWING PURPOSES UNDER LIMITED CIRCUMSTANCES.**

**As Required by Law:** We may use and disclose information about you as required by law. Light Touch Physical Therapy may disclose information for judicial and administrative proceedings, pursuant to legal authority; to report information related to victims of abuse, neglect, or domestic violence; and to assist law enforcement officials in their law enforcement duties.

**For Public Health:** Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

**Health and Safety:** Your health information may be disclosed to avert a serious threat to the health and safety of you and or any other person pursuant to applicable law.

**Family and Friends:** If you are unavailable to communicate, such as in a medical emergency or disaster relief, we may disclose your personal and health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

**Law Enforcement:** We may disclose limited information to law enforcement officials concerning the personal and health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the personal and health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution.

**Military and National Security:** We may disclose to military authorities the personal and health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials personal and health information required for lawful intelligence, counterintelligence, and other national security activities.

**Workers Compensation:** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation or similar programs which provide benefits for work-related injuries or illness.

**Business Associates:** We may disclose limited health information to Business Associates that perform functions on our behalf of provide us with services if the information is necessary for such functions or services. Our Business Associates are required to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our agreement or as required by law.

**Data Breach Notification:** We may use your contact information to provide legally required notices of the unauthorized acquisition, access or disclosure of your health information.

**OTHER USES OF YOUR HEALTH INFORMATION:** Other uses and disclosures of your medical information not covered by this Notice or required by laws that apply to us will be made only with your written permission (Authorization). If you provide your permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke permission, we will no longer use or disclose medical information about you for the reasons indicated in your written authorization. You understand that we are unable to take back any disclosures that we made before we received your written notice revoking your Authorization. You may submit your request in writing using the contact information listed at the end of this Notice.

## **YOUR HEALTH INFORMATION RIGHTS**

**Right to Request Additional Restrictions.** You have the right to request restrictions in our use or disclosure of your medical information for treatment, payment or healthcare operations explained in this Notice. You must submit your request in writing using the contact information listed at the end of this Notice. While we will consider all requests carefully, we are not required to agree to your request for restrictions EXCEPT for a request for a restriction on disclosure of your medical information to your health plan for purposes of payment if the restriction pertains *solely* to a health care item or service that you have paid for entirely out-of-pocket.

**Right to Receive Paper Copy of the Notice.** You have the right to receive a paper copy of this Notice. Please contact us by using the information listed at the end of this Notice.

**Right to Inspect and Copy Your Confidential Information.** You have the right to inspect and receive a paper or an electronic copy of your medical record and billing records. We may charge a reasonable cost-based fee associated with your request. Under limited circumstances, we may deny you access to a portion of your records. You may submit your request in writing using the contact information listed at the end of this Notice.

**Right to Amend Your Health Records.** You have the right to ask us to amend your medical information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our organization. If we determine that the record is inaccurate, and the law permits us to amend it, we will correct it. If your treating physician or another person created the information that you want changed, you should ask that person to amend the information. You may submit your request in writing using the contact information listed at the end of this Notice.

**Right to Receive Confidential Communications:** You have the right to request that we communicate with you about your health and related issues in a particular manner, or at a certain location. While we will consider reasonable requests, we are not required to agree to all requests. You may submit your request in writing using the contact information listed at the end of this Notice.

**Right to Receive an Accounting of Disclosures.** You have the right to request an accounting of the disclosures we have made of your medical information for purposes other than specified above. All requests for an accounting of disclosures may not contain a period longer than six years and may not include dates before April 14, 2003. If you request an accounting more than once during any 12-month period, we will charge you a reasonable fee for each accounting statement after the first one. We will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs. You may submit your request in writing using the contact information listed at the end of this Notice.

**Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. To file a complaint with us you may submit your complaint using the contact information listed at the end of this Notice. We will not take any action against you if you file a complaint with the Secretary of the Department of Health and Human Services or us.

**CHANGES TO THIS NOTICE:** We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will post a copy of the current Notice in our facility and on our website. Revised notices will be made available to you upon request.

**IF YOU HAVE A REQUEST:** If you wish to make any of the requests listed above under “Your Health Information Rights,” please submit your request in writing to:

Light Touch Physical Therapy  
7800 Cooper Rd., Suite 104  
Cincinnati, OH 45242  
Fax: 513-792-0203

This notice is effective as of today’s date listed below.

I have read the Privacy Notice and understand my rights contained in the Notice. By way of my signature I provide Light Touch Physical Therapy with my authorization and consent to use and disclosed my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ (Patient Signature)