

NOTICE OF PRIVACY PRACTICES

Effective February 12, 2007

THIS NOTICE DESCRIBES HOW ACUPUNCTURE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I am required to maintain the privacy of your protected health information and provide you with notice of my legal duties and privacy practices with respect to such protected health information.

I am required to abide by the terms of the notice currently in effect. I reserve the right to change the terms of my notice at any time and to make the new notice provisions effective for all protected health information that I maintain. A copy of the current notice will be posted in the office. If you should have any questions or require further information, please contact Kathy Veon, DOM, AP at 407-328-6711.

How I May Use or Disclose Your Health Information

The following describes the purposes for which I am permitted or required by law to use or disclose your health information without your consent or authorization. Any other uses or disclosures will be made only with your written authorization and you may revoke such authorization in writing at any time.

Treatment: I may use acupuncture information about you to provide you with acupuncture treatment or services. I may disclose acupuncture information about you to doctors, nurses, technicians, acupuncture students or other personnel who are involved in taking care of you. I may share acupuncture facilities in order to coordinate your treatment.

Payment: I may use and disclose acupuncture information about you so that the treatment and services you receive at my office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, I may need to give your health plan information about treatment you received at my office so your health plan will pay me or reimburse you for the treatment. I may also tell your health plan about a treatment you are going to obtain prior to approval or to determine whether your plan will cover treatment.

Health Care Operations: I may use and disclose acupuncture information about you for office operations. These uses and disclosures are necessary to run the office and make sure that all of my patients receive quality care. For example, I may use acupuncture information to review my treatment and services and evaluate my performance in caring for you.

Business Associates: There may be instances where services are provided to my office through contracts with third party "business associates". Whenever a business associate arrangement involves the use or disclosure of your health information, I will have a written contract that requires the business associate to maintain the same high standards of safeguarding your privacy that I require of my own employees and affiliates.

Required by Law: I will disclose acupuncture information about you when required to do so by federal, state or local law.

Communication with Family or Friends: Using my best judgment, I 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.

Marketing: I may use or disclose your health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Research: I 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.

Coroners, Medical Examiners and Funeral Directors: I may disclose health information to a coroner or medical examiner. I may also disclose acupuncture information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, I may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Public Health: As required by law, I may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Food and Drug Administration (FDA): I 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.

Worker's Compensation: I may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

To Avert a Serious Threat to Health or Safety: Consistent with applicable federal and state laws, I may use and disclose health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans: If you are a member of the armed forces, I may disclose health information about you as required by military command.

Health Oversight Activities: I may disclose health information to a health oversight agency for activities authorized by law, including audits, investigations, inspections, and licensure.

Protective Services for the President, National Security and Intelligence Activities: I may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security authorized by law.

Law Enforcement: I may disclose health information when requested by a law enforcement official as part of law enforcement activities; investigations of criminal conduct; in response to court orders; in emergency circumstances; or when required to do so by law.

Inmates: I may disclose health information about an inmate of a correctional institution or under the custody of a law enforcement official to the correctional institution or law enforcement official.

Lawsuits and Disputes: I may disclose health information about you in response to a subpoena, discovery request, or other lawful order from a court.

Your Rights Regarding Your Health Information

The following describes your right regarding the health information I maintain about you. To exercise your rights, you must submit your request in writing to: Kathy Veon, DOM, AP, 3300 W. Lake Mary Blvd., Suite 330, Lake Mary, FL 32746.

Right to Request Restrictions: You have the right to request that I restrict uses or disclosures of your health information to carry out treatment, payment, health care operations, or communications with family or friends. I am not required to agree to a restriction.

Right to Receive Confidential Communications: You have the right to request that I send communications that contain your health information by alternative means or to alternative locations. I must accommodate your request if it is reasonable and you clearly state that the disclosure of all or part of that information could endanger you.

Right to Inspect and Copy: You have the right to inspect and copy acupuncture information that may be used to make decisions about your care. Usually, this includes acupuncture and billing records, but does not include psychotherapy notes. To inspect and copy acupuncture information that may be used to make decisions about you, you must submit your request in writing. If you request a copy of the information, I may charge a fee for the costs of copying, mailing or other supplies associated with your request. I may deny your request to inspect and copy, in certain very limited circumstances. If you are denied access

to acupuncture information, you may request that the denial be reviewed. Another licensed health care professional will review your request and the denial. The person conducting the review will not be the same person who denied your request. I will comply with the outcome of the review.

Right to Amend: You have the right to have me amend your health information for as long as I maintain such information. Your written request must include the reason or reasons that support your request. I may deny your request for an amendment if I determine that the record that is the subject of the request was not created by me, is not available for inspection as specified by law, or is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures”. This is a list of the disclosures I made of acupuncture information about you. To request this list or accounting of disclosures, you must submit your request in writing. Your request must state a time period, which may not be longer than six years, and may not include dates before February 12, 2007. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12 – month period will be free. For additional lists, I may charge you for the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred.

Right to Obtain a Paper Copy: You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.

How to File a Complaint if You Believe Your Privacy Rights Have Been Violated

**Kathy Veon, DOM, AP
3300 W. Lake Mary Blvd., Suite 330
Lake Mary, FL 32746**

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

CONSENT FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

This notice provides information about how I may use and disclose protected health information about you. As provided in the notice, the terms of the notice may change. If I change this notice, a revised copy will be made available to you. By signing this form, you consent to my using and disclosing protected health information about you for the limited purposes of receiving treatment from me, obtaining payment for the healthcare services provided to you, and my own health care operations. You have the right to revoke this consent, but such revocation must be made in writing. Your revocation will be honored on the day that it is signed, except where I have already made disclosures in reliance on your prior consent.

I agree to the terms contained within this consent:

(Patient's Signature)

(Printed Name)

(Date)