

NOTICE OF PRIVACY PRACTICES

ARBOR MEDICAL SERVICES, P.C. ("ARBOR"), ALPHA REHABILITATION ("ALPHA") AND MEDICALLY-BASED FITNESS ("MBF")

Effective Date: April 14, 2003

Version: September 1st, 2011

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.

WHO WILL FOLLOW THIS NOTICE?

- ° HEALTH CARE PRACTITIONERS WHO TREAT YOU AT ANY OF THE ARBOR, ALPHA AND MBF FACILITIES, AND EMPLOYEES, VOLUNTEERS, TRAINEES, INTERNS AND MEMBERS OF OUR STAFF
- ° ALL DEPARTMENTS AND OPERATING UNITS OF OUR COLORADO PROVIDER NETWORK

OUR DUTIES REGARDING MEDICAL INFORMATION

This Notice of Privacy Practices describes how we may use and disclose your "protected health information" ("PHI") to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. We will explain each category and give some examples where necessary. Not every use or disclosure in a category will be listed. This Notice also describes your rights and obligations regarding the use and disclosure of medical information. "Protected health information" is the information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your medical providers, office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services pertaining to your care. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Another example is that your protected health information may also be disclosed to your physician who referred you to therapy services in order to effectively manage your case.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining authorization for medical and/or therapy services may require that your relevant protected health information be disclosed to the health plan or insurance carrier to obtain approval for the medical and/or therapy services.

Research Purposes: Your protected health information may be used to determine the efficacy of your treatment. In this case, information that identifies you will be removed so others may use your PHI to study healthcare and delivery without learning the identity of the specific patients.

Healthcare Operations: We may use or disclose your protected health information to carry out activities that are necessary to run our facilities and to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.

Contacts and Appointment Reminders: We may use or disclose your protected health information, as necessary, when calling to inform you of appointments or information about treatment alternatives or other health-related benefits and services.

Emergencies: We may use or disclose your protected health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency.

Miscellaneous: We may use or disclose your protected health information without your authorization for several other reasons. These situations include, as required by law: public health issues as required by law; communicable diseases; health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroner; funeral directors and organ donation; research; criminal activity; military activity and national security; workers compensation; inmates; and other legally required uses and disclosures. Under the law, we must take disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Workers' Compensation: By law, we may use or disclose your protected health information without your authorization for payment purposes and for other reasons required by law, including, without limitation, to provide medical reports and work restrictions to you and to your employer, to the extent required or allowed by Colorado workers' compensation laws. For example, your protected health information may be used or disclosed to your workers' compensation insurance carrier or for

such activities as billing, determinations of eligibility or coverage, and review of health care services with respect to medical necessity, appropriateness of care, justification of charges, or those necessary for preauthorization of services.

Other Permitted and Required Uses and Disclosures: Other uses and disclosures will be made only with your written authorization and you may revoke such authorization as provided by law.

You may revoke this authorization, at any time, in writing, except to the extent that Arbor, Alpha and MBF have taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

Following is a statement of your rights with respect to your protected health information.

Right to Inspect and Copy: In most cases, you have the right to inspect or copy your medical information when you submit a written request. We may deny your request in certain circumstances. If you are denied access to your medical information, you may appeal.

Right to Amend: If you believe the information in your record is incorrect or incomplete, you have the right to request an addendum be added to your record by submitting a written request giving your reason. We may deny your request in certain circumstances. If we deny your request, 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.

Right to Request Restrictions: You have the right to request that we follow additional, special restrictions when using or disclosing your PHI for treatment, payment or health care operations. You also have the right to request 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 be in writing and must state the specific restriction requested, whether you want to limit our use or disclosure or both, and to whom you want the restriction to apply.

We are not required to agree to your request for a restriction, but we will consider it. For example, if a provider 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. Another example is that we cannot agree to certain restrictions on use or disclosure of certain PHI in workers' compensation cases.

Right to Request Confidential Communications: You have the right to request that your medical information be communicated to you in a confidential manner, such as sending mail to an address other than your home. Your request must be submitted in writing to us.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this Notice of Privacy Practices upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

Right to an Accounting of Disclosures: You have the right to a list of those instances where we have disclosed your medical information other than for treatment, payment, healthcare operations or where you specifically authorized a disclosure. To request an accounting of disclosures, you must submit a written request.

Changes to this Notice: We reserve the right to change this notice at any time. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as for any information we receive in the future. We will post a copy of our current Notice within our facilities and also on our website.

Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. Your complaint must be in writing and must include the details of the basis for your complaint. Your complaint must be submitted to our HIPAA compliance officer (please call our Broomfield office at 303-460-9151 for the identity of that officer). You will not be retaliated against for filing a complaint.

This version is effective as of **September 1st, 2011**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or by phone at our Broomfield office at 303-460-9151.

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of our Notice of Privacy Practices. We encourage you to review it carefully. Our Notice of Privacy Practices is subject to change. If we change our Notice, you may obtain a copy of the revised Notice upon request.

I acknowledge receipt of this Notice of Privacy Practices.

Print

Name: _____ Signature: _____ Date: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative: _____ Date: _____

Reason(s) why the acknowledgement was not obtained:

Patient refused to sign.

Other

comments: _____

