Rachel Stewart, DNP, APRN, FNP
4160 Heritage Trace Parkway,
Suite 400
Keller, Texas 76244

Phone: 817-431-6160
Fax: 817-431-6190

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN HAVE ACCESS TO THIS INFORMATION - PLEASE REVIEW IT CAREFULLY.

HOPE FAMILY HEALTHCARE is issuing this Notice of Privacy Practices about the information we share in common, your legal rights, and our common duties with respect to your health information.

OUR PLEDGE TO YOU

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We maintain a record of the care and services you receive from us. We need this record to provide you with quality care, bill for your care, and comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether made by our staff and authorized trainees, or by your provider. This notice tells you about the ways in which HOPE FAMILY HEALTHCARE may use and/or disclose health information about you. We also describe your rights to this health information and describe our obligations regarding the use and/or disclosure of your health information.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

HOPE FAMILY HEALTHCAE providers and staff members may use health information about you to provide you with health care treatment or services. We may also disclose health information about you to others who are involved in taking care of you. For example, we may send health information about you to a specialist as part of a referral.

HOPE FAMILY HEALTHCARE may use and disclose health information about you to obtain payment for the treatment and services you receive from us. For example, we may send billing information to your insurance company or Medicare. We may also tell your insurance company

about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. HOPE FAMILY HEALTHCARE will send you a statement of your account if payment is due from you. We may send the guarantor (financially responsible party) monthly statements for charges for all patients under that guarantor.

HOPE FAMILY HEALTHCARE may use and disclose health information about you to support our health care operations. For example, we may use health information to review the treatment and services and to evaluate the performance of our staff in caring for you. We may combine health information about many patients to decide what additional services we should offer. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are. We may disclose information to notify a family member or other person responsible for your care about your condition, status, and/or location.

We may use and disclose health information to contact you for an appointment reminder, to tell you about health-related services, or recommend possible treatment options or alternatives that may be of interest to you.

Subject to certain requirements, we may use or disclose health information about you without your prior authorization for other reasons: We may give out health information about you for public health purposes; to report abuse or neglect; for health oversight reviews; in research studies; for funeral arrangements and organ donation; in response to special law enforcement requests, valid judicial or administrative orders, or for authorized national security and intelligence activities; to avert a serious threat to your health or safety or those of the public or another person; and when required by law. If you are or were a member of the armed forces, we may release information about you as required by military command authorities or the Department of Veterans Affairs. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. In any other situation not covered by this notice (i.e. marketing, remuneration), we will ask for your written authorization before using and/or disclosing your health information. You may revoke this authorization for any subsequent disclosures by notifying us in writing.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to request in writing that you inspect and obtain a copy of the health information that we use to make decisions about your care. We may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. If we deny your request to inspect or obtain a copy in certain limited circumstances, you may appeal that denial with us. A licensed health care professional chosen by HOPE FAMILY HEALTHCARE will review your appeal and the denial and we will comply with the outcome of that review.

If you believe that health information we have about you is incorrect or incomplete, you may make a written request to ask us to amend information. The request should state the reason for

the amendment and specific information to be amended. The amendment must be limited to one page. Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously stated. We may deny your request for an amendment if the information to be amended was not created by us, is no longer maintained by us, is not part of the information which you would be permitted to inspect and copy, or is accurate and complete. We will notify you in writing if we deny your request for amendment and you may appeal our decision in writing. Any statements of disagreement or rebuttal will be linked to your health information and made a part of any subsequent disclosure we make of such information.

You have the right to make a written request for a list of disclosures we have made of your health information, except for uses and disclosures for treatment, payment, and health care operations, as previously described, and those for which you have authorized disclosure. Your request must state a time period which may not be longer than six years. We will not charge you for the first list you request within a 12-month period; additional requests will be charged according to our cost for producing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to request a restriction on the health information we use or disclose about you for treatment, payment, or health care operations. There may be risks associated with such restrictions and we may ask you to acknowledge these risks in writing for certain requests you may make. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or if we are required by law to release the information. If you have paid out-of-pocket for a healthcare item or service in full, we must honor your request to restrict the information that is disclosed to a health plan for purposes of payment or operations.

You have the right to request, in writing without requiring you to state a reason, that confidential communications with you be made in an alternative manner or location. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. You have the right to be notified of a breach of unsecured protected health information (PHI) in the event that you are affected.

REQUESTS/QUESTIONS

If you have any questions about this notice, please contact: Hope Family Healthcare at 4160 Heritage Trace Parkway, Suite 400, Keller, Texas 76244 or at 817-41-6160.

COPIES AND CHANGES OF NOTICE OF PRIVACY PRACTICES

You have the right to obtain a paper copy of this notice at any time. We reserve the right to change this notice, and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.

COMPLAINTS

If you are concerned that your privacy rights may have been violated or you disagree with a decision we make about your health information, you may contact Hope Family Healthcare at 4160 Heritage Trace Parkway, Suite 400, Keller, Texas 76244 or at 817-41-6160. You may also send a written complaint to the U.S. Department of Health and Human Services.

Please sign the attached acknowledgement that you have received our Notice of Privacy Practices.

I acknowledge that I have received and fully understand the NOTICE OF PRIVACY PRACTICES from HOPE FAMILY HEALTHCARE.

_____	_____
Patient Name	Date
_____	_____
Patient Signature (or signature of Parent/Guardian)	Relationship to Patient