

NOTICE OF PRIVACY PRACTICES

This Notice of privacy Practice is NOT an authorization. It describes how our Business Associates and their subcontractors may use and disclose your Protected Health Information to carry out treatment , payment , or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "Protected Health Information. "is information that identifies you individually, including demographic information that relates your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your Protected Health Information in the following situations:

- **Treatment:** We may use or disclose your protected Health Information to provide medical treatment and/ or service in order to manage and coordinate your medical care for example, we may share your medical information with other physicians and health care providers, DME vendors, surgery centers, hospitals , rehabilitations therapists , home health providers, laboratories, nurse case managers, workers compensations adjusters, etc. to ensure that the medical provider has the necessary medical information to diagnose and provide treatment to you .
- **Payment:** your protected health information will be used to obtain payment for your health care service. For example, we will provide your health care plan with the information it requires prior to paying us for the services we have provided to you. This use and disclosure may also include certain activities that your health plan requires prior to approving a service such as determining benefits eligibility and prior authorization, ect.
- **Health Care Operations:** we may use and disclose your Protected Health Information to manage, operate, and support the business activities of our practice. These activities include but not limited to manage and support the business activities including medical research, clinical trials. In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your Protected Health Information, as necessary to contact you to remind you of your appointment, and inform you about treatment alternatives or other health –related alternatives or other health-related benefits and services that may be of interest to you.
- **Minors:** Protected Health Information of minors will be disclosed to their parents or legal guardians, unless prohibited by law.
- **Required By Law:** We will disclose your Protected Health Information when require do to do so by local, state, federal and International law.
- **Abuse, Neglect, and Domestic Violence:** Your Protected Health Information will be disclosed to the appropriate government agency if there is belief that a patient has been or is currently the victim of abuse, neglect or domestic violence and the patient agrees or it is required by law to do so in addition, your information may also be disclosed when necessary to prevent serious threat to your health safety or the safety of others to someone who may be able to help prevent the threat.
- **Your individual rights:**

You have the right to:

1. Look at or get copies of certain parts of your medical information. You must make request in writing and charges may apply.
2. Request that we place additional restrictions on our use of disclosure of your medical information. We are not required to agree to these additional restrictions. But if we do we will abide by our agreement (except in the case of an emergency).

Only the most common use and disclosure have been listed not every use or disclosure has been listed. Not every use or disclosure has been listed if you wish to get the entire listing of uses and disclosure you may request this and we can provide it directly to you. This notice of privacy practices is a summary highlighting the most common uses and disclosures seen in our practice. This is done in order to make process more understandable for our patients. If you wish to have a full length copy, please ask us to provide in writing.

By signing below I understand the Notice of Privacy Practices and get copy to take home whenever I want.

Signature of Patient/ Legally Authorized Representative

Date

If signed by legal representative, please indicate relationship to patient _____

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