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**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.**

The terms of this Notice of Privacy Practices apply to the organization, the physicians who refer to our practice and other licensed professionals involved in your care. All members of this clinically integrated health care team work with the organization to assure high quality care. All of the entities and persons listed will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. Only the minimum amount of information required will be shared.

We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to your protected health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all protected health information maintained by us. You may receive a copy of any revised notices from the organization's administration office or a copy may be obtained by mailing a request to the organization. A copy of the Notice is also available electronically on our Web Site at: [www.promotionrehab.com](http://www.promotionrehab.com).

If a use or disclosure of your protected health information under the HIPAA Privacy Ruling is prohibited or otherwise limited by another State or Federal law applying to the information, we are required to follow the more stringent law.

We are required by law to notify you if there is breach of your protected health information by us or by our Business Associates.

**HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION**

Unless we have listed it below, we will not use or disclose your protected health information for any purpose unless you have signed a form consenting to or authorizing the use or disclosure. You have the right to revoke that consent or authorization in writing unless we have taken any action in reliance on the consent or authorization. The following categories describe different ways that we may use and share your health information without further authorization:

**For Treatment:** We may make uses and disclosures of your protected health information as necessary for your treatment. For example, information obtained by a physical therapist or other health care practitioner will be recorded in your record and will be used to determine your plan of care. This information may be provided to your physician or other healthcare professionals to assist in treating you.

**For Payment:** We may make uses and disclosures of your protected health information as necessary for payment purposes. For instance, we may forward information regarding your therapy treatment to your insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment.

**For Health Care Operations:** We may use and disclose your protected health information as necessary, and as permitted by law, for our health care operations which include quality improvement, professional peer review, business management, accreditation and licensing, etc. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may use your health information to contact you at the address and telephone number(s) you provide (including leaving a message at the telephone numbers) about scheduled or cancelled appointments, registration/insurance updates, billing and/or payment matters.

**Business Associates:** Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide certain of your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

**Directories:** We do NOT maintain an organization directory listing your information. No information that you provide us as part of your care and treatment will be included in a directory.

**Family and Friends Involved in Your Care:** With your approval, we may from time to time disclose your protected health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

**Appointments and Services:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You may request such confidential communication in writing and may send your request to the Privacy Officer.

**Research:** In limited circumstances, we may use and disclose your protected health information for research purposes. For example, a researcher may wish to compare outcomes of all patients that received a particular drug and will need to review a series of medical records. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board or privacy board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

**Fundraising:** For fundraising purposes to support **Certain Non-Profit Organizations** and their mission provided, however, that such information is limited to demographic information only such as name, address, phone number, age or gender. If we contact you for fundraising purposes, you will be provided with information on how to remove yourself or opt out of receiving future fundraising solicitations

#### **Other Uses and Disclosures**

We are permitted or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization.

- **Required by Law:** We may release your protected health information for any purpose required by law; We may release your protected health information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
- **Public Health Activities:** We may release your protected health information for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
- **Suspected Abuse and Neglect:** We may release your protected health information as required by law if we suspect child abuse or neglect; we may also release your protected health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence;
- **Product Recalls:** We may release your protected health information to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
- **Employer Request:** We may release your protected health information to your employer when we have provided health care to you at the request of your employer; in most cases you will receive notice that information is disclosed to your employer;
- **Court Order:** We may release your protected health information if required to do so by a court or administrative ordered subpoena or discovery request; in most cases you will have notice of such release;
- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement:** We may release your protected health information to law enforcement officials as required by law to report wounds and injuries and crimes;
- **Coroner:** We may release your protected health information to coroners or funeral directors consistent with law;
- **Organ and Tissue Donation:** We may release your protected health information if necessary to arrange an organ or tissue donation from you or a transplant for you;
- **Military and Veterans:** We may release your protected health information if you are a member of the military as required by armed forces services; we may also release your protected health information if necessary for national security or intelligence activities; and
- **Worker's Compensation:** We may release your protected health information to workers' compensation agencies if necessary for your workers' compensation benefit determination.
- **National Security and Intelligence Activities:** We may release health information about you to an authorized federal official(s) for intelligence, counter-intelligence and other national security activities authorized by law.
- **Protective Services for the President and Others:** We may disclose health information about you to authorized officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.
- **Inmates:** 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.

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**RIGHTS THAT YOU HAVE****Access to Your Protected Health Information**

You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We will charge you \$0 per page if you request a copy of the information. We will charge for postage if you request a mailed copy and will charge for preparing a summary of the requested information if you request such summary. You may obtain an access request form from the Medical Records or Business Office staff. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Amendments to Your Protected Health Information**

You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form from the Medical Records or Business Office staff.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person/entity that created the information is no longer available to make the amendment
- Is not part of the health information kept by or for our practice
- Is not part of the information which you would be permitted to inspect and copy, or
- Is accurate and complete.

**Accounting for Disclosures of Your Protected Health Information**

You have the right to an accounting of any disclosures of your health information we have made, except for uses and disclosures related to treatment, payment, others with your permission and our health care operations, as previously described. To request this list of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing 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.

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**Restrictions on Use and Disclosure of Your Protected Health Information**

You have the right to request restrictions on certain of our uses and disclosures of your protected health information for treatment, payment, or health care operations on the consent form you sign when you become a patient. For example, you could ask that we do not disclose information to your spouse regarding your treatment. Unless the request is to restrict disclosures to your health plan and you agree to pay out of pocket in full for all services provided, 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 emergency treatment. If you have paid for a health care item or service in full, out of pocket, we must honor your request to restrict information from being disclosed to a health plan for purposes of payment or operations. To request a restriction, you must make your request in writing to the Privacy Officer. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction to sending such termination notice to the Medical Records department and/or Privacy Officer.

**Marketing and Fundraising**

We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money for special fundraising projects and you will have the right to opt out of receiving such communications with each solicitation. You are free to opt out of fundraising solicitation, and your decision will have no impact on your treatment or payment for services. You have the right to request that we not send you any future marketing or fundraising materials, and we will use our best efforts to honor such request. You may make the request by sending your name and address to the Privacy Officer with your request to be removed from our marketing and fundraising mailing lists.

**Confidential Communications**

You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box. To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Paper Copy of This Notice**

You have the right to obtain a paper copy of this notice at any time. To obtain a copy please request it from the Clinic Front Office Clerk or our Privacy Officer. This notice is also posted on our website at: [www.promotionrehab.com](http://www.promotionrehab.com).

**Complaints**

If you believe your privacy rights have been violated, you can file a complaint in writing with the organization's Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

**FOR FURTHER INFORMATION**

If you have questions or need further assistance regarding this Notice, you may contact the Privacy Officer at one of the following appropriate locations:

PRO MOTION REHAB & WELLNESS CENTER  
2810 US HWY 64 W, SUITE 1  
MURPHY, NC 28906  
828-837-0400

As a patient you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.

**EFFECTIVE DATE**

This Notice of Privacy Practices is effective September 23, 2013.



**PATIENT ACKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES**

Patient Name: \_\_\_\_\_

I acknowledge that I was provided with a copy of the Pro Motion Rehab HIPPA Notice of Privacy Practices for Personal Health Information.

**Release of Information**

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to the following:

**Please check and list names below.**

[ ] Spouse \_\_\_\_\_

[ ] Child(ren) \_\_\_\_\_

[ ] Other \_\_\_\_\_

[ ] Information is not to be released to \_\_\_\_\_

[ ] Information is not to be released to anyone. This Release of Information will remain in effect until terminated by me in writing.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Representative

\_\_\_\_\_  
Authority to Act

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**For Pro Motion Rehab, Inc. use only:** Complete this section if this form is not signed and dated by the patient or patient's representative and no signed acknowledgement of receipt of the current notice of privacy practices is on file in the patient's chart

Patient [  has  has not ] signed an acknowledgement of the CURRENT Notice of Privacy Practices either attached here or as documented in the patients chart.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

The date that you requested the signature: \_\_\_\_\_

The reason that the signature and date were not obtained: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_