

ELIZABETH A. LIOTTA, MD, LLC

NOTICE OF PRIVACY PRACTICES

This practice has implemented the following policies and procedures to ensure the confidentiality of your personal and/or medical information. Federal and state laws require us, to maintain the privacy of your health information.

Your physician(s) and all other employees working in the practice will keep any information related to you (medical and/or non-medical) in a confidential manner. However, so that we may provide you with appropriate medical care, for general practice operations and or for the purposes of obtaining payment, we will, at our discretion provide information pertaining to the treatment you received in this practice, the charges for this treatment and related information regarding the treatment and charges to other health care related entities. This information will be submitted through the following mechanisms: US Postal Service, fax submission, Internet submission, voice mail and/or personal communications. The following is a list of the most common types of entities that we most typically would provide personal health related information. This list is not an all-inclusive list. Other entities may be added to this list.

- Physicians and non-physician providers (i.e. physician therapist, nutritional counselors) who work outside of this practice.
- Medical facilities (i.e. hospitals, outpatient centers).
- Laboratories for the purposes of running medical tests.
- Other health care providers, such as pharmacies, durable medical equipment suppliers, ambulance services.
- School health departments.
- Insurance companies (or third party administrators) for the purpose of obtaining payments, reviewing medical necessity and or general case management.
- State or Federal agencies that require the submission of specific health related information.
- Billing services.

We may need to contact you, by phone, to discuss your appointments, test results, treatments, referrals, account balance and/or to return your phone call. We will first attempt to contact you at home, however if you are not available and you provide us with your work number, we will attempt to contact you at work. If you are not available, we will leave a message for you to either call the office for a specified reason (i.e. discuss test results, account balance) or we will remind you of your appointment time.

In the event you do not pay all of your charges in full at the time of your visit, we will mail a statement to your home. Also, depending upon your situation, we may mail recall cards to your home noting that you need to contact the office to schedule an appointment. Periodically, we may mail test result information to your home. We will use the home address you provided us with at the time you register with the practice.

We may contact your insurance company to determine your coverage, eligibility, unmet deductible and/or your co-insurance and co-pay requirements. If necessary for obtaining payment, we will provide credit bureaus and/or collection agencies with your account information.

When you arrive at our practice for your appointment, we will ask you to sign in and note your arrival time. We will do our very best to see you promptly. However, there may be times when your provider is running behind schedule and you will need to wait in the waiting room.

If you would like information sent to another physician or medical facility, you may be asked to authorize the release of this information, in writing (we will provide you with the necessary form to complete). Also, you must provide written authorization for the release of information to your life or disability insurer.

You may review and/or obtain a copy of your medical record. You may request, in writing, changes be made to your medical record. We will review your reason(s) for such a request and if we agree, will make the change(s). If we do not agree with your request, you are entitled to have your statement added to the record. Also, you may request information regarding who we have disclosed your medical information to for purposes other than treatment, payment and health care operations.

Please provide us with current information regarding your phone numbers (work and home) and home billing address. This will allow us to make the correct contact when trying to reach you.

When necessary these policies will be modified to ensure compliance with practice operations and with State and Federal privacy regulations.

If you have any questions or concerns with the policies and/or procedures noted above, please contact our practice manager at the above address and phone number to report any and all concerns. We trust that you are comfortable with our sincere efforts to maintain the confidentiality of the information related to your medical care. If you believe we have not maintained the privacy of your records, you may file a complaint with the Secretary of the US Dept. of Health & Human Services. There will be no retaliation for filing a complaint.

I _____ acknowledge the receipt of these policies and consent to their use relevant to the information in my medical record.

Signature: _____ (Seal) _____ Date _____ (Witness)

Effective Date: _____