Lloyd Bellah, M.D.
Adult and Geriatric Psychiatry

1650 W. Virginia; Suite 202
McKinney, Texas 75069
(972) 542-5980

Notice of Privacy Practices

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.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

The privacy of your medical information is important to us.
We understand that your medical information is personal and we are committed to protecting it. Please note, we will create a record of the care and services you receive in our office in the course of your treatment. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will outline our legal duties, explain the ways we may use and share your medical information, and describe your rights regarding the use and disclosure of our medical records.

OUR LEGAL DUTIES

Law Requires Us to:

- Keep your medical information private.
- Give you this notice describing our legal duties, privacy practices, and your rights.
- Follow the terms of the current notice.

We Have the Right to:

- Change our privacy practices and the terms of this notice at any time as permitted by law.
- Make any changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

We Must:

- Provide you with a revised *Notice of Privacy Practices* if we make changes in our privacy practices. Any new notice would be available upon request or at your next office visit.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes some of the ways that we routinely use and disclose medical information. Understandably, due to space constraints, not every possible use or disclosure can be listed in this notice. However, we pledge not to use of disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

For Treatment: We may use and disclose your medical information to provide you with medical treatment or services. We may provide medical information about you to doctors, nurses, technicians or other people who assist in caring for you. We may also share medical information about you to your other health care professionals to assist them in treating you.

For Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or to a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations: We may use and disclose your medical information for our health care operations, the business aspects, of running our practice. This might include quality control, audit functions,

cost-management analysis, and customer service. As well as, obtaining the accreditation, certifications, licenses, and credentials we need to serve you.
For Law Enforcement: We may use and disclose your medical information to law enforcement agencies to support government audits, inspections, investigations, and to comply with government mandated reporting. Your records may also be subject to valid subpoenas, court orders or other requests by law enforcement officials.

For Public Health Reporting: We may use and disclose your medical information to public health agencies as required by law.

Additional Uses of Information

Appointment Reminders: Your health information will be used by our staff to contact you for appointment reminders.
Information about Treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find interesting.

YOUR INDIVIDUAL RIGHTS

You Have a Right to:

- Request to look at or obtain copies of certain parts of your medical information and receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, health care operation, and other specified exceptions.
- Request that we place additional restrictions on the use or disclosure of your medical information. Note, 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.
- Request that we communicate with you about your medical information by different means or to different locations.
- Request we change certain parts of your medical information. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information. However, we may deny your request if we did not create the information you want changed or for other ethical or legal reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed.
- Request additional paper copies of this document.

All requests regarding these rights must be made in writing to the contact person listed at the end of this notice. We will require you to complete a form for our records. If you request copies, we will charge you $25.00 for the first 25 pages and $.50 for each page thereafter. Additionally, you may request that we provide copies in a format other than photocopies. We will follow your request unless it is not practical for us to do so.

QUESTIONS AND COMPLAINTS

Please contact us if you have any questions about this notice or if you think that we may have violated your privacy rights. You may submit a complaint or make a request involving any of your rights by writing to us at:

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We can, at your request, provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), this notice is effective as of October 1, 2008 and remains in effect until we replace it.

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Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as a part of my healthcare, Dr. Bellah and his office staff originate and maintain health records describing my health history, symptoms, examinations, test results, and treatment plans. I understand that this information will be utilized to plan my future care, to bill for services rendered, to communicate with healthcare providers, and perform other routine healthcare operations.

I understand that, under the **Health Insurance Portability and Accountability Act of 1996** (HIPPA), I have certain rights to privacy regarding my protected health information.

I understand that The *Notice of Privacy Practices* provides more specific information of how my personal health information may be used and disclosed.
I have been provided a copy of the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this *Acknowledgement of Receipt.*

I understand that Dr. Bellah reserves the right to change the *Notice of Privacy Practices* and that I may contact the office at any time at the address above to obtain a current copy of the notice.

I understand that I may request in writing to restrict how my private information is used or disclosed.
I understand that Dr. Bellah is *not* required to agree to my restrictions, but if he does the office is bound to abide by such restrictions.

I understand that I may revoke this consent at any time in writing except to the extent that Dr. Bellah or the office staff has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

You may refuse to sign this acknowledgement

_____
Please Print Name

_____
Signature Date

_____
Relationship to the Patient if Applicable

OFFICE USE ONLY

I attempted to obtain the patient's signature in *Acknowledgement of Receipt of Notice of Privacy Practices*, but was unable to do so as documented below:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited me from obtaining the acknowledgement
- ☐ An emergency situation prevented me from obtaining the acknowledgement
- ☐ Other (Please Specify)

_____
Signature Date