HIPAA NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt • HIPAA Notice of Privacy Practices

PRO MEDICAL

We understand that health information about you is personal and we are committed to protecting it. We create a record of the care, services and assessments you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the health related records of your care generated by PRO Medical, whether made by your personal treating practitioner or others working within PRO Medical. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights regarding the health information we keep about you, and describe certain obligations we have regarding the use and disclosure or your health information.

WE ARE REQUIRED BY LAW TO:

- Make sure that health information that identifies you is kept private.
- Give you this Notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

- For treatment.
- For payment.
- Check-in at the front desk for non-members of PRO Medical.
- For health care operations.
- For appointment reminders.
- As required by law.
- To avert a serious threat to health and safety.
- As required by the Military, Veterans Administration or Workers Compensation authorities.
- To avoid public health risks.
- To provide health oversight activities.
- As required for lawsuits and disputes.
- In support of law enforcement.
- As requested by coroners, health examiners and funeral directors.
- To comply with National Security and Intelligence activities.
- As required to provide Protective Service for the President and others.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

- Rights to inspect and copy.
- Right to amend.
- Right to accounting of disclosures.
- Right to request restrictions.
- Right to request confidential communications.
- Right to a paper copy of this notice.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice. We will retain an archived copy of all versions of this notice.

COMPLAINTS:

If you believe that your privacy rights have been violated you may file a complaint with us. All complaints must be in writing to: PRO Medical, ATTN: HIPAA Officer, 4455 148th Avenue NE, Bellevue, WA 98007.

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE:

We will request that you sign page 2 of this notice acknowledging you have received a copy of this notice. This acknowledgement will become part of your records.

BELLEVUE
4455 148TH AVENUE NE
BELLEVUE, WA 98007
P: (425) 861-6255
F: (425) 861-6245

SEATTLE
501 EASTLAKE AVE E
2ND FLOOR
SEATTLE, WA 98109
P: (206) 292-3826
F: (206) 343-4340

WILLOWS ROAD
9911 WILLOWS ROAD, #100
REDMOND, WA 98052
P: (425) 869-4750
F: (425) 869-4751

PRO CLUB

PRO MEDICAL

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ACKNOWLEDGEMENT OF RECEIPT

I, ______________________________, *(please print)* acknowledge receipt of a copy of the notice of Privacy Practices of PRO Medical.

______________________________ ______/______/______

Patient (age 13 or older) or Personal Representative Signature *Month* *Day* *Year*

PERSONAL AUTHORIZATION

I authorize PRO Medical to disclose the following information to the contact details below, per my request.

- ☐ All health care information in my medical record.
- ☐ Insurance billing information.
- ☐ Health care information in my medical record relating to the following treatment:

____

- ☐ Other *(appointments, test results, etc.)*

______________________________ (______)______________

E-Mail Address *Fax Number*

(______)______________ Confidential Voicemail? ☐ Yes ☐ No

Phone Number

AUTHORIZATION OF ADDITIONAL PARTIES

Please include the names of persons with whom we are allowed to discuss your medical condition and/or billing information.

______________________________ ______________________________

Name *Relationship*

______________________________ ______________________________

Name *Relationship*

- ☐ All health care information in my medical record.
- ☐ Insurance billing information.
- ☐ Health care information in my medical record relating to the following treatment:

____

- ☐ Other *(appointments, test results, etc.)*

SIGNATURE

I authorize PRO Medical to discuss my billing and or medical condition with the above named person(s).

______________________________ ______/______/______

Patient (age 13 or older) or Personal Representative Signature *Month* *Day* *Year*

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