HIPAA Notice of Privacy Practices for Personal Health Information (PHI)

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.

Dear Thrive HQ Patient:

This is your Health Information Privacy Notice from Thrive HQ. You are receiving this notice as mandated by law to inform you of the policies and procedures employed by this clinic and its staff in order to ensure the privacy of your Personal Health Information (PHI). This notice also describes your rights with respect to you PHI and how you can exercise those rights. PHI includes individually identifiable health information in any form, including information transmitted orally, or in written or electronic form.

We are required by law to:

1. Notify patients about their privacy rights and how their PHI can be used.
2. Adopt and implement privacy procedures.
3. Train employees so that they understand the privacy procedures.
4. Designate an individual responsible for ensuring that privacy practices are adopted and followed.
5. Secure patient records containing individually identifiable health information.

Permitted Uses and Disclosures

The HIPAA Privacy Rule generally requires that we make reasonable efforts to limit the use or disclosure of, and requests for, PHI to the minimum necessary to accomplish the intended purpose. We may use/disclose your PHI without consent in the following cases:

1. Treatment: The provision, coordination or management of health care and related services among health care providers or by health care provider with a third party, consultations between health care providers regarding a patient, or the referral of a patient by one health care provider to another.
2. Payment: The various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their covered responsibilities, and to obtain or provide reimbursement for the provision of health care. This includes determining eligibility or coverage under a plan, adjudicating claims, billing and collection activities and justification of charges.
3. Health Care Operations: Administrative, financial, legal and quality improvement activities necessary to run our business including quality assessments, review of competence and qualifications of health care workers, accreditation, conducting or arranging for medical review, legal and auditing services and business management.

Your PHI may also be used/disclosed to inform you of health related products or services provided by Thrive HQ, alternative treatments or therapies, or in any communications made during a face to face encounter with you.

Special Uses and Disclosures

Your PHI may be used/disclosed without your authorization in the following special circumstances;

- Law enforcement activities.
- Public health risks or activities.
- Reports to appropriate authorities concerning victims of abuse, neglect or domestic violence.
- Health oversight activities and government benefit programs.
- Judicial and administrative proceedings (court order, warrant, and court subpoena for relevant information.
- Emergency situations with serious threats to health or safety.
- Specialized government functions.
- Worker's compensation.
- Appointment reminders.
- Individuals involved (family/friends) in your care or payment for your care.
- Research, if conducted without using information that could reveal your identity.
- Military and Veterans, as required by military command authorities.

We may use/disclose your PHI for other purposes if you authorize the specific use/disclosure in writing. You may revoke this authorization at any time, but it must be in writing.

Your Rights Concerning Your PHI

- You have the right to access and copy your "designated record set" (any piece of information that reflects a decision a provider makes regarding the patient). You may request that your record set, or portions of it, be copied. This request must be made in writing and may be subject to a reasonable copying charge. We have 30 days (50 in certain circumstances) to deliver the requested material to you.
- You have the right to receive an accounting of disclosures of your PHI. This excludes disclosures made to carry out treatment, payment or health care operations. An account would include disclosures made during the 6 years prior to the date of the request, and the date, recipient's name(s), description of PHI disclosed, and statement of purpose for the disclosure for each disclosure.
- You have the right to request amendments or corrections of your PHI. You must submit this request (see contact information at end of this notice) in writing and provide the reason for this request. In some circumstances we may have the right to deny your request. We will explain the reason for any denials, and you may have the right to appeal the denial.

- You have the right to request additional restrictions or special limitations regarding how we use or disclose your PHI. We may deny this request, but if we agree to it then we will be legally obligated to carry out the agreement. This request must also be made in writing.
- You have the right to request alternative means of communications to increase confidentiality. You must specify how communication is to be carried out (written, phone, electronic, etc.) and any other limitations (specific address or phone number, etc.) in a written request. We will honor reasonable requests.
- You have a right to receive a paper copy of this notice. We will issue a copy of this to you at the start of your course of treatment, and request that you sign a form stating that you have received this form.

Changes to Privacy Practices
We have the right to make revisions to this notice and to our privacy practices at any time. Revisions will apply to all PHI that we currently have, and any PHI that we obtain or generate in the future. Revisions will be posted with this notice in our clinic and on our website.

Questions and Complaints
If you have any questions about this notice, or would like an additional copy, please contact us at the information listed below. If you feel that we have violated your privacy rights or disagree with a decision that has been made regarding your PHI, you may file a complaint with the Privacy Officer listed below, and/or with the Secretary of the U.S. Dept. of Health and Human Services. Please note that you will not be penalized for filing a complaint with us or DHHS.

Thrive HQ
Attn: Privacy Officer, Matthew Hirn
3511 Lake Elmo Ave N
Lake Elmo, MN 55042
(651) 383-2626

You will not be penalized or otherwise retaliated against for filing a complaint. I ACKNOWLEDGE that I have received a copy of Thrive HQ's notice of privacy practices. I understand that this information describes how Thrive HQ may disclose and use any protected health information.

Member Name: _____

Date of Birth: _____

Acknowledgement of Receipt of Privacy Practices Notice

I, _____ (print name of patient or patient's personal representative), acknowledge that I have received a copy of Thrive HQ's Notices of Privacy Practices. This notice provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information. By signing, you acknowledge that you have reviewed this Notice.

_____

Signature of Member or Personal Representative Date

Consent to Leave Messages

To ensure confidentiality and comply with the Health Insurance Portability and Accountability Act (HIPAA), we ask that you let us know where and with whom we are permitted to leave information about your upcoming appointment, account information or any other information you may want us to convey via telephone or electronic messaging:

May we leave information on your mobile or home phone voice mail? **YES / NO**

May we leave a message with someone who answers the phone at your residence? **YES / NO**

May we leave a message at your place of employment? **YES / NO**

May we call you partner, spouse, or emergency contact person to leave information? **YES / NO**

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Signature of Member or Personal Representative Date