Physical Therapy / Fitness Center

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.

THERAFIT, LLC is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Our Privacy Officer is: M. Kay Hanson
Our Practice Phone Number is: 256-829-9544
Our Practice Fax Number is: 256-829-9522
Our Practice Address is: 12819 Hwy 231/431 N. Suite G, Hazel Green, AL 35750

DISCLOSURE OF YOUR HEALTH INFORMATION

TREATMENT
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations. (example)

> "On occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers associated with THERAFIT, LLC."
> "It is our policy to provide a substitute healthcare provider, authorized by THERAFIT, LLC to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary healthcare provider's absence due to vacation, sickness, or other emergency situation."

PAYMENT
We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations. (example)

> "As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to THERAFIT,LLC for healthcare services rendered. If you pay for your healthcare services rendered. If you pay for your healthcare services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the healthcare services received."

WORKERS' COMPENSATION
We may disclose your health information, as necessary, to comply with State Workers' Compensation Laws.

EMERGENCIES
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

PUBLIC HEALTH
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS.
We may disclose your health information in the course of any administrative or judicial proceeding.

LAW ENFORCEMENT.
We may disclose your health information to a law enforcement official for purpose such as identifying or location a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

DECEASED PERSONS.
We may disclose your health information to coroners or medical examiners.

ORGAN DONATION.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

RESEARCH
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

PUBLIC SAFETY
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

SPECIALIZED GOVERNMENT AGENCIES

We may disclose your health information for military, national security, prisoner and government benefits purposes.

MARKETING

We may contact you for marketing purposes or fundraising purposes, and described below: (example)

"As a courtesy to our patients, it is our policy to call your home in the evening prior to your scheduled appointment to remind you of your appointment time. If your are not at home, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time or your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such and event. It is not our policy to disclose any personal health information about your condition for the purpose of THERAFIT, LLC sponsored fund-raising events."

CHANGE OF OWNERSHIP

In the event that THERAFIT, LLC is sold or merged with another organization, your health information/record will become the property or the new owner.

YOUR HEALTH INFORMATION RIGHTS

*You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that THERAFIT, LLC is not required to agree to the restriction that you requested.

*You have the right to have your health information received or communicated through and alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

*You have the right to inspect and copy your health information.

*You have a right to request that THERAFIT, LLC amend your protected health information. Please be advised, however, that THERAFIT, LLC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.

*You have the right to receive an accounting of disclosures of your protected health information made by THERAFIT, LLC.

*You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

THERAFIT, LLC reserves the right to amend this Notice or Privacy Practices at any time in the future, and will make the new provision effective all information that it maintains. Until such amendment is made, THERAFIT, LLC is required by law to comply with this notice.

THERAFIT, LLC is required by law to maintain the privacy of your health information and to provide you with notice, or its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our Privacy Officer by calling our office. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

COMPLAINTS

Complaints about your privacy rights, or how THERAFIT, LLC has handled your health information should be directed to our Privacy Officer, whose name is stated above. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of April 14, 2003.

I have read the Privacy Notice and understand my rights contained in the notice.

By way or my signature, I provide THERAFIT, LLC with my authorization and consent to use and disclosed my protected health care information for the purpose of treatment., payment, and health care operations as described in the Privacy Notice.

Patient's Name (print)_____

Patient's Signature:_____ Date_____

Authorized Facility Signature:_____ Date_____