

NOTICE OF PRIVACY POLICY – Pro Natural Health Center 医本堂 <https://sendsafe.to/pronaturalhealth.ctr@gmail.com>

Pro Natural Health Center is dedicated to providing services with respect for human dignity. Protecting your privacy and health care information is fundamental in the course of our relationship. This notice describes how medical information about you may be used and disclosed by Pro Natural Health Center and how you can get access to this information. Please review this notice carefully, it will remain in effect until it is replaced or amended by changes in law.

You Have Following Rights:

Right to Inspect and Copy: With some exceptions, you have the right to inspect and get a copy of your health copy in certain limited circumstances, and if we do this, you may ask that denial be reviewed. A fee will be charged to copy your record.

Right to Amend: You have the right to amend your health information maintained by or for Pro Natural Health Center, or used by us to make decision about you. We will require that you provide a reason for the request, and we may deny your request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create, (unless the source of the information is no longer available to make amendment); (b) is not part of the health information that we keep; (c) is of a type that you would not be permitted to inspect and copy; or (d) is ready accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures. This is list of certain disclosures we made of your health information. The list does not include all disclosures. For example if does not include disclosures to you, disclosures for treatment, payment and health care operations purposes described above, or disclosures made with your Authorization as described above.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you (a) for treatment, payment, or health operations or (b) to someone who is involved in your care or the payment for it, such as a family member or friend. For example, you could ask that we not use or disclose information about a treatment you had. We are not required to agree to your request, and any time Pro Natural Health Center agrees to a restriction, it must be in writing and signed by Pro Natural Health Center or it's designee.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain place. For example, you can ask that we only contact you at work or by mail.

Right to Paper Copy of This Notice: You have the right to copy of this notice on your first visit. You have the right to request additional copies of this notice or any revisions from the front desk receptionist.

Users and Disclosures of Health Information for Treatment, Payment and Health Operations

For Treatment: We may use your health information to provide you with medical services. We may disclose your health information to healthcare team.

For Payment: We may use and disclose your health information so that we may bill and collect payment from you, an insurance company, or someone else of health are service you receive from Pro Natural Health Center. Example, a bill may be sent to you, your health insurance company, or the responsible party. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedure and any supplies used. In some cases, information from your medical record is sent to your insurance company to explain the need for or provide additional information about your treatment.

For Health Operations: We may use and disclose your health information in order to run the necessary administrative, business functions and quality assurance at Pro Natural Health Center. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about patients to help us decide what additional services we should offer, how we can improve efficiency, or whether certain treatments are effective.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

I, _____, have read, received, understood, and agreed to the statement of the Privacy Policy for healthcare services by this clinic.

Patient (Guardian) Signature: _____ Date: _____