HIPAA Notification
Electronic Communications
Informed Consent

Compass Housecalls, PLLC

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the information carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act give you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilizing review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and
abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested

restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required to maintain by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

The notice is effective as of February 01, 2016 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. Please contact our office with any concerns or questions.

Name_____

Signature:_____Date:_____

CONSENT TO VIDEO CHAT/Telecommunications

By signing below, I hereby consent to current and future use of video chats and HIPAA complaint communications (as applicable) for my medical visit via video conference call and/or texting. I understand that (Compass Housecalls PLLC) will take all appropriate and available actions to help keep these visits safe and secure. I release (Compass Housecalls PLLC, from any and all liability and responsibility associated with any possible and accidental release of personal health information.

Signature:_____Date:_____

INFORMED CONSENT

By signing below, I hereby consent to health care management and treatment by (Compass Housecalls PLLC). I acknowledge that it is my responsibility as a patient to seek out information needed regarding my diagnosis, management, treatment plan, and medications. I agree to be a partner in my health care and in decisions related to my care.

Signature:_____Date_____