Gulf Women's Center for Health & Surgery
Tammy L. Birbeck DO

NOTICE OF PRIVACY PRACTICES

This Notice briefly describes how medical information about you may be used and disclosed and how you can get access to this information, please review it carefully. You have the right to obtain a paper copy of this Notice upon request. For a complete copy of the Privacy Practices please visit https://www.hhs.gov/hipaa

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. **How We Use Your Patient Health Information**

We use health information about you for treatment, to obtain payment, and fog health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the' quality of treatment, and to assess the care-and outcomes of your case and others like it.

Special Uses: We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of Interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

- Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- Judicial and administrative proceedings: We may disclose Information in response to an appropriate subpoena or court order.
- Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
- Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
- Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
- Research: We may use or disclose information for approved medical research.

- Workers Compensation: We may release Information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any Identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights about your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with y6u confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your information. There may be a small charge for the copies.
Amend Information: If you believe that • information in your record is Incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations. **Our Legal Duty**

We are required by law to protect and maintain the privacy of your health information provide this Notice about our legal duties and privacy practices regarding protected health Information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each, examination roam. You can also request a copy of our Notice at any time. For more Information about our privacy practices, contact the person listed below. **Complaints**

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below, you also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint. **Contact Person**

If you have any questions, requests, or complaints, please contact:

Name: Tammy L Birbeck
Title: Physician
2061 Englewood Road Suite 4, Englewood, Fl 34223-1747
Phone Number: 941-681-2042

Acknowledgment of Receipt of Notice of Privacy Practices

I have read and understand ***Gulf Women's Center for Health & Surgery*'s** HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that ***Gulf Women's Center for Health & Surgery*** has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, ***Gulf Women's Center for Health & Surgery*** will post a new notice in the office. I may contact ***Gulf Women's Center for Health & Surgery*** at any time to obtain a current copy of the HIPAA Notice of Privacy Practices.

Patient Printed Name	Patient Signature	Date
Authorized Individual (Parent/Guardian) Name	Authorized Individual Signature	Date

Gulf Women's Center for Health & Surgery
Tammy L. Birbeck DO

Gulf Women's Center for Health & Surgery
OFFICE FINANCIAL POLICY

Thank you for choosing Gulf Women's Center for Health & Surgery as your health care provider. We are committed to providing you with quality and affordable health care. The last several years have been a time of profound change regarding health care reform. It has become necessary to implement the following policies. **PLEASE REVIEW THOROUGHLY AND SIGN THIS SHEET CONFIRMING THAT YOU UNDERSTAND AND READ THIS FORM IN ITS ENTIRITY.**

Insurance:
Knowing your insurance benefits Is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage and financial obligation such as deductibles, copays, and co insurances. Services that are not covered or specified by your plan will be your financial responsibility. Our staff will confirm your insurance benefits and estimate share of cost when applicable. Policies that charge by percentage rate or deductible amount will be at our discretion and we will notify you of the estimate. Additional fees, if any, will be due immediately upon receipt of statement.

Co-Payments and Deductibles:
All co-payments and deductible amount must be paid at the time of service and will be collected upon check in. This arrangement is part of your contract with your insurance company and failure to pay can be considered breach of contract or fraud. Unpaid balances such as deductibles and copays could result in cancellation of your health care benefits. If an additional amount is due, we require full payment upon receipt of the Invoice. We do not accept partial payments or payment plans.

Physician Participation, Coverage and /or Coverage Changes, Proof of Identity and Proof of Health Insurance:
Although we accept most insurances, it is the patient's responsibility to confirm of our participation with your specific network. Please contact your insurance carrier directly and provide them with the name of the Physician, address and they will provide you with this information.
We must obtain a copy of your insurance card and picture Identification for our records. All patient Information forms are required to be completed with up to date information, prior to receiving medical care. Failure to do so would result in a cancellation of the appointment.

HMO or PPO Patients requiring a referral:
You are responsible for making sure your visits with our office are authorized by your primary care physician ((PCP) unless otherwise specified that an authorization is not required. The authorization must be obtained prior to your scheduled visit. It is the patient's responsibility to ensure that we have received the authorization required. If you are unsure if you need authorization, look in the back of your card or contact the customer phone number for confirmation.

Claims Submission and Your Responsibility:
As a courtesy we will submit your claims and assist you in any way we reasonably can to help get a claim paid. An explanation of benefits (EOB) will be sent by the insurance carrier for your review after the claim has been received. Any missing information that is requested must be sent by you for the claim to be processed.
Please be aware that the balance of your claim is your responsibility even if your insurance company fails to pay your claim, we allow 30 days from the date of billing for your Insurance payment. The health insurance benefit is a contract between you and your insurance company only. We are not party to your specific contract.

Outstanding Balances, Past Due Accounts and Explanation of Benefits:
If your account is 45 days past due, you will receive a final letter stating that you have 15 days to make full payment. Please be aware that we may send your account to a collection agency. You and your immediate family members will be discharged from this practice. In the event of discharge, you will be notified by certified mail that you have 30 days to find an alternative health care provider. During that period our physician will only be able to treat you on an emergency basis.

Remember, you and/or your employer pay the monthly insurance premiums. Your insurance company is accountable to you. Do not hesitate to contact them if you have any questions regarding your policy and financial responsibilities.

By signing below, you agree that you have read the form and agree to the terms of our policy.

_____ Date:_____
Responsible Party Signature

_____ Relationship to patient: ( ) Self ( )Guarantor ( ) Other: _____
Printed Name