Navigating Wellness Primary Care
50 Columbia Street #11, Suite 62
Bangor, ME - 04401-6331

1 NWPC HIPAA & Consent NOTICE_OCT2024

Navigating Wellness Primary Care, PLLC

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HIPAA NOTICE OF PRIVACY PRACTICES

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

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your clinician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of Navigating Wellness Primary Care and affiliate practitioners, and any other use required by law.

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes coordinating or managing your health care with a third party. For example, we may disclose your protected health information, as necessary, to a home health agency that provides care to you. Your protected health information may be provided to a clinician to whom you have been referred to ensure that the clinician has the necessary information to treat you.

In addition, we may also call you by name in the waiting room when your clinician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Use as required by law

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation.

YOUR RIGHTS:

The following is a statement of your rights with respect to your protected health information.

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

You have the right to inspect and copy your protected health information.Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.
This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may have the right to have your clinician amend your protected health information. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. We will not retaliate against you for filing a complaint or request to amend your medical record.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

By signing and submitting this form I acknowledge that I have been provided ample opportunity to read this document or that it has been read to me. I acknowledge that I have reviewed the Notice of the Privacy Practices. Lastly, I understand all of the above and give my oral and written consent to the evaluation and treatment to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

I have read this and understand.
PATIENT SIGNATURE: * _____

Today's Date: * _____

Release of Information

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I hereby authorize the release of my medical information for the purposes of insurance billing, continuity of care, and necessary healthcare operations. This authorization includes, but is not limited to, information required for ordering imaging, laboratory tests, or referrals to other healthcare providers.

Additionally, I authorize the release of my medical information to the following insurance payer(s) for claims processing and payment purposes. I understand that this authorization will remain in effect until I revoke it in writing or it otherwise expires under applicable law.

Purpose of Release

-Personal Use

-Continuity of Care

-Legal

-Insurance Claims Processing

Expiration of Authorization

I understand that this authorization will remain in effect for one year from the date signed, or until I submit a written revocation.

Patient Rights

I understand that:

-I have the right to revoke this authorization at any time by submitting a written request to Navigating Wellness Primary Care PLLC (NWPC). This revocation will take effect upon receipt of my written request and will not affect any actions taken prior to that time.

-Revoking this authorization may impact NWPC's ability to bill my insurance for services rendered. I understand that if I choose to revoke this authorization, I may be personally responsible for covering the costs associated with my care.

-I am not required to sign this authorization to receive treatment at NWPC. My decision to sign or not sign this authorization will have no impact on the quality of care I receive or my ability to access services.

-I have the right to receive a copy of this authorization for my records.

PATIENT SIGNATURE _____

Date _____

Printed Name of SIGNER (and relationship to patient if not signed by patient): _____