Healthy Horizons Clinic

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 ***

Healthy Horizons Clinic ("Practice") may use your health information, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Probability and Accountability Act of 1996, for purposes of providing you treatment, obtaining payment for your care, and conducting health care operations. The Practice has established policies to guard against unnecessary disclosure of your health information.

Our Responsibilities

We are required by law to maintain the privacy of your health information and to provide you with a description of our practices. We will abide by terms of this notice and notify you if we cannot agree to a requested restriction. We will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Uses and Disclosures

How we may use and disclose Medical Information about you.

The following categories describe examples of the way we use and disclose medical information.

For Treatment: We may use medical information about you to provide you with treatment services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other Practice personnel who are involved in taking care of you at our office. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healthy process. Different departments of the Practice may also share medical information about you in order to coordinate the different things you may need, such as prescriptions, lab work, and x-rays. We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you.

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I, _____, have reviewed and verified that the information regarding my demographics and my insurance that I provided is accurate and valid for billing. Any delays, incurred charges, or balances that occur due to missing and/or incorrect insurance and/or demographic information will result in patient responsibility.

Patient Name (Print): _____

Signature: _____

Date: _____