ANDREW J. SACCO, OD, FAAO
DANIEL J. KIRCHHEIMER, OD
400 Plaza Drive Suite B
Vestal, NY 13850

NOTICE OF PRIVACY PRACTICES

Policy Number:
14A

Effective Date _____

In order to comply with HIPAA's Privacy Rule, it is the policy of this office to:

1. Distribute a Notice of Privacy Practices ("NPP") to every patient at their first appointment, eyewear pickup, or similar encounter on or after April 14, 2003.

- The NPP to use is attached to this Policy. Only [insert name or title] has authority to change this NPP.
- [Insert name/title] is responsible to distribute the NPP.
- [Insert name/title of responsible person from paragraph b.] must give the patient a copy of the NPP when [specify appropriate point in encounter].
- [Insert name/title of responsible person from paragraph b.] must ask the patient to sign an acknowledgement of receipt of the NPP ("AOR") and general consent. The AOR and general consent to use is attached to this Policy. Put all signed AORs and consent in [selected location in your office].
- If the patient opts not to sign the AOR, [insert name/title of responsible person from paragraph b.] must make a note of the fact that you asked and that the patient refused. Put this note in [selected location in your office where you keep AORs.]
- It is not necessary to give a NPP to a patient every time they come in after April 14, 2003 unless we change the NPP.
    - At every patient encounter, [insert name/title of responsible person from paragraph b.] must look in [specify location in your office where AORs of NPPs are stored] to determine if the patient has previously signed an AOR.
    - If yes, it is not necessary to give that patient another NPP unless we have changed our NPP since the date of the AOR. Our most current NPP will always have an effective date on the front.
    - If no, then it is necessary to distribute a NPP and ask for signature on an AOR.
- If our first encounter with a patient after April 14, 2003 is electronic, our electronic system will automatically send a NPP and ask for a signed AOR.

2. Post a copy of our NPP on [specify a prominent location in your office].

3. Keep a stock of copies of the NPP in [specify an accessible location in your office] so that patients and visitors can take one, if they wish.

4. Redistribute our NPP as above whenever we change it.

5. We will use and disclose protected health information in a manner that is consistent with HIPAA and with our NPP. If we change our NPP, the revised NPP will apply to all protected health information that we have, not just protected health information that we generate or obtain after we have changed the NPP.

Effective date of notice: _____

NOTICE OF PRIVACY PRACTICES

ANDREW J. SACCO, O.D., FAAO
DANIEL J. KIRCHHEIMER, OD
400 Plaza Drive, Suite B Vestal, NY 13850
607 798-1987
607 729-8277

Privacy Officer: Lorri Hertzog

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. We will send letters to physicians who have referred you to our office for care detailing the results of your visit here and suggested treatment. We may also send letters to your designated primary health care physician should we feel the findings of your visit here is pertinent to your overall health. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" means those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; and business planning.

We routinely use your health information inside our office for these purposes without any special permission. We also share your information with other health care providers, insurers, and administrative entities when necessary in order to provide appropriate treatment, secure payment, or carry out administrative functions. We ask for your consent to the disclosure of your health information for the purposes of treatment, payment and health care operations by signing the "Acknowledgement of Receipt and General Consent" attached to this form and returning it to us.

USES AND DISCLOSURES FOR OTHER REASONS

The law also allows or requires us to use or disclose your health information without a specific authorization for other reasons. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- to governmental authorities about victims of suspected abuse, neglect or domestic violence;

- for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- for health related research, subject to the approval of a privacy board, which must follow a special approval process;
- to prevent a serious threat to health or safety;
- for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- for purposes of worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

We ask that you consent to the disclosure of your health information for the reasons listed above by signing the "Acknowledgement of Receipt and General Consent" attached to this Notice and returning it to us.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make another appointment with us. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we may mail you an appointment reminder via post card, letter, or email and/or leave you a reminder message on your home answering machine. We may also leave a message with someone who answers your phone if you are not available to take the call.

GLASSES OR CONTACT LENS NOTIFICATION

We may notify you that your eyeglasses or contact lenses are ready via post card or email if we cannot reach you by telephone. We may also leave a message on your home answering machine or work voice mail if you are not available. We may also leave a message with someone who answers your home telephone if you are not available. Periodically we may contact you regarding your eyewear or contact lenses.

APPOINTMENT REMINDERS

We may occasionally send thank you notes to those who refer patients to our office. We may also send sympathy cards to family members if someone is deceased. We may also acknowledge via email, letter, post card or phone call a patients birthday or special event.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a specific "authorization form." While the Acknowledgement of Receipt and General Consent form contains general language allowing us to use and disclose your health information for treatment, payment, health care operations and other purposes permitted by law, the authorization form more specifically describes the purpose of the use or disclosure,

the nature of the information that will be used or disclosed and the persons or groups of persons to whom the information will be made available. The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

HIV-RELATED INFORMATION AND INFORMATION CONCERNING ALCOHOL AND SUBSTANCE ABUSE SERVICES

New York State law includes special protections for HIV-related information. We will not disclose information concerning your HIV status or HIV testing without obtaining a specific written authorization, except under certain circumstances in which such a disclosure is authorized or required by law. For example, we would be permitted to disclose such information to certain agents or employees of your health care providers that are authorized to obtain such information for treatment or payment purposes, to health care facility staff committees and health care facility accreditation or oversight organizations, to a public health officer when mandated by law, to your health insurer or vision plan for purposes of securing reimbursement if we obtained your general consent to such disclosures, pursuant to a court order and certain other purposes.

Health information possessed by federally-supported alcohol and substance abuse treatment programs is also subject to special protections under federal law. If we receive information about you from one of these programs, we will not re-disclose it without your specific written authorization, except under circumstances in which such a disclosure is authorized or required by law, such as to medical personnel who need this information for the purpose of providing you with emergency treatment, to the Food and Drug Administration for the purpose of identifying potentially dangerous products, for research purposes if approved by our privacy board, to authorized persons conducting on-site audits of our records, subject to the requirement that these persons not remove the information from our facilities and agree in writing to safeguard the information; and in response to an appropriate court order.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review your records within 10 days and receive a copy within a reasonable time or have a copy of your health information within 10 days. You are also specifically entitled to obtain copies of your eyeglass or contact lens prescription upon your request. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to

persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT AND GENERAL CONSENT

I acknowledge that I read and received or was offered a copy of Dr. Sacco's Notice of Privacy Practices.

I further consent to the release of my health information for purposes of treatment, payment, and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority: _____

I authorize my medical information to be released to: _____-_
Print name

_____
Patients Signature