Steve Clark ND PLLC

Dr. Steve Clark ND
Dr. Erik O Nelson ND

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.

NOTICE OF PRIVACY PRACTICES

In the course of your care as a patient of Dr. Clark's, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital for the purposes of providing, managing and/or coordinating healthcare or healthcare related services. For example, your case may be discussed between Dr. Clark and his staff.
- Your healthcare records, as well as your billing records, may be disclosed to another party such as an insurance carrier, HMO or PPO, an attorney, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and your healthcare records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of some interest to you.
- We may use and disclose your health information in connection with other healthcare operations. This includes quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- If you are not at home to receive an appointment reminder, a message may be left on your answering machine or voice mail system. You have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Your authorization:

- You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

To your family & friends:

- If you agree, we may disclose your health information to a family member, friend or other persons to the extent necessary to help with your healthcare or with payment for your healthcare. Your family or friends are permitted in the room during your treatment with your permission. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up supplies, medicinary items, labs or other similar forms of health information.

Alternative communication:

- We normally provide information about your health to you in person at the time you receive treatment from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences. Your request must specify how payments will be handled under the alternative means or location you request.

Persons involved in care:

- In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care. If you are present, we will provide you with an opportunity to object to the use or disclosure of your health information prior to such uses or disclosures.

Marketing health related services:

- We will not use your health information for marketing communications without your written permission on the Patient Authorization form.

Required by law:

- We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices, our legal duties, and your rights with respect to your health information.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing healthcare services to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Abuse or neglect:

- We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Patient Rights:

Amendment & Access

- You have the right to inspect and/or copy your health information, with limited exceptions, for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Your request must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address on the front of this Notice. If you request copies, we will charge you $0.25 for each page, $20 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you.

Disclosure Accounting

- You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last six years but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Electronic Notice

- If you receive this Notice on our web site or by electronic mail (email) you are entitled to a hard copy.

- ❖ We reserve the right to alter or amend the terms of this privacy notice but we are required by law to abide by the terms of this Notice while it is in effect. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.
- ❖ Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.
- ❖ If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, you may issue your complaint to us by contacting the privacy officer on the front of this form. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with their address upon request.
- ❖ This Notice is effective as of June 1srt, 2021. This Notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this Notice.

Name (print:) Signature: Date:

If you are a minor, or if you are being represented by another party:

Representative (print) Representative signature: Date:

Description of authority of person acting on behalf of the patient: