

Mari Ann Herbert, D.O., LLC

Notice of Privacy Practices

This notice takes effect on April 14, 2003 and remains in effect until we replace it.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

OUR PLEDGE REGARDING HEALTH INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive from us because we need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. It will also describe your rights and certain duties we have regarding the use and disclosure of medical information.

1. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we are permitted to use and disclose medical information. Not every use or disclosure is listed, but each use or disclosure falls into one of these categories. Any use or disclosure of your medical information for any purpose not listed below requires a written consent from you, which you may revoke at any time in writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are involved in your care. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.

For Payment:

We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your insurance company information about your office visit so your insurance plan will pay us or reimburse you for the visit.

For Health Care Operations:

The use and disclosure of health care information may be necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to evaluate the performance of our staff in caring for you. We may also use information for accreditation, certificates, licenses, and credentials we need to serve you. We may use health care information in providing appointment reminders to our patients.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

- As required by law
- Disaster relief
- Workers' Compensation
- Public health risks
- Health oversight activities
- To avert a serious threat to health or safety
- Specialized government functions (Military or Veterans)
- Court orders, judicial & administrative proceedings
- Victims of abuse, neglect, or domestic violence
- Law enforcement

2. YOUR INDIVIDUAL RIGHTS

You have a right to inspect and copy your medical information.

You must make your request in writing to the attention of Medical Records and allow two weeks for processing. We will request that you complete our release form and pay a fee of \$10.00 to cover our cost of copying the records.

You have the right to an accounting of disclosures.

You may request a listing of disclosures of your health information made for purposes other than treatment, payment, or operations. Your request must be submitted per directions below.

You have the right to request restrictions on information released.

For example, you could ask that we not disclose information to your spouse about a surgery you had. We are not required to agree to your request if we feel it will have a negative impact on your care. If we do agree, we will abide by our agreement. Your request must be submitted per directions below.

You have the right to request confidential communications.

You may request that we communicate with you about health matters in a certain way or at a certain location. For example, you may ask that we only contact you at work. Your request must be submitted per directions below.

NOTE: All requests for information or other specific requests must be submitted in writing.

3. OUR LEGAL DUTY

We are legally required to: Keep your medical information private. Provide you with this notice regarding our legal duties, privacy practices, and your rights regarding your medical information. Follow the terms of this notice that is now in effect.

We have the right to: Change our privacy practices and the terms of this notice at any time, provided when changes are permitted by law. Make the changes effective for all medical information that we keep, including information previously created or received before the change.

We will: Make any changes in our privacy practices available upon request before we implement them.

4. QUESTIONS AND COMPLAINTS

Please address questions or complaints to phone (630) 920-2600

If you think that we may have violated your privacy rights, please contact our office. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Mari Ann Herbert, D.O.
Cosmetogynecology-Cosmetic Medicine
Medical Spa & Wellness Center, LLC
700 Pasquinelli Drive, Suite B
Westmont, IL 60559
630-920-2600 office 630-920-2707 fax

Receipt of Notice of Privacy Practices

(Type on lines then tab to next)

I, _____, hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available to me.

Signed: _____ Date: _____

Authorization of Release of Protected Health Information to Family Member:

I authorize Dr. Mari Ann Herbert of staff member, to release protected health information to my family member(s) listed below:

Name: _____ Relationship: _____

Signed: _____ Date: _____

Confidential Communications:

I request Dr. Mari Ann Herbert or staff member to communicate with me at the alternate location or phone number listed below:

Address (street, city, state, zip)

Phone Number (area code, phone number)

Signed: _____ Date: _____