Patient Name: «FirstName» «LastName»

This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

NOTICE OF INFORMATION PRACTICES

1. *P.R.I.M.A., Inc*. may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool, life insurance or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for Claims including coordination of benefits with other insurers or collection agencies. Healthcare operations include but are not limited to, internal quality control and assurance including auditing of records.

2. *P.R.I.M.A., Inc*. is permitted or required to use or disclose protected health information without the written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court order.

3. We may release protected health information for workers' compensation or similar programs.

4. *P.R.I.M.A., Inc*. will not make any other use or disclosure of a patient's protected health information without written authorization. Such authorization may be revoked at any time. Revocation must be written.

5. *P.R.I.M.A., Inc*. may at times contact the parent/custodial parent of the patient to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient.

6. We may release protected health information about your child to a friend or family member who is involved in their medical care. We may also give information to someone who helps pay for their care. You will be provided a form to list specific people who we may speak to regarding your child's medical care. In addition, we may disclose protected health information about your child to an entity assisting in a disaster relief effort so that your family can be notified about their condition, status and location.

7. *P.R.I.M.A., Inc*. will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.

8. *P.R.I.M.A., Inc*. reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains.

9. *P.R.I.M.A., Inc*. will provide each parent of a patient with a copy of any revisions of its Notice of Information Practice, if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our office.

10. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the following address and/or phone number (401) 333-5201. All complaints will be addressed and the results will be reported to the (Corporate Compliance Officer/Managing/Physician/Board of Directions).

11. It is *P.R.I.M.A., Inc*. policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

12. The name, title and telephone number of a person in the office to contact for further information is E. James Monti, MD, (401) 333-5201.

13. The effective date is April 14, 2003.

Patients have been granted individual rights under the HIPPA Legislation.
These include the following.

1. You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes, information compiled in reasonable anticipation of or use in a civil, criminal or administrative action or proceeding, or Protected Health Information that is subject to or exempt from the Clinical Laboratories Act of 1988. To inspect and copy protected health information that may be used to make decision about you, you must submit your request in writing to the Privacy Officer listed above. If you request a copy of the information , we may charge a fee for the costs of copying (including labor), mailing or other supplies associated with your request.

2. If you feel that the protected health information we have about you is incorrect or complete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is maintained in the designated record set. To request an amendment, your request must be made in writing and submitted to the Privacy Officer listed above. You must provide a reason that supports your request and we may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment, is not part of the protected health information kept by or for our practice; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our organization will review your request and the denial. The person conducting the review will not be the person who denied your request and we will comply with the outcome of the review.

3. You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of protected health information about you that was not made for treatment, payment and health care operations, there are certain exceptions to this right. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer listed about. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. The accounting must be provided to you no later than 60 days after the receipt of your request, unless we utilize the 30-day extension period.

4. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care of the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer listed above. In your request, you must tell us (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply, for example, disclosures to your spouse. Either you or we may terminate the restriction upon notification of the other.

5. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer listed above. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You will be asked to sign an acknowledgement of receipt of the Notice of Privacy Practices. You will Also be asked to outline or define specific instances or information that you would like kept completely confidential (between you and the organization). If you have any questions regarding this Notice of Privacy Practices, please do not hesitate to contact our Privacy Officer for more information or clarification.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of ***P.R.I.M.A., INC.'s*** Notice of Privacy Practices.

Name of Patient: «FirstName» «LastName»

____ Date: __________

Signature of patient or personal representative

____

If signed by personal representative,
relationship to patient

Office Use Only:

P.R.I.M.A., Inc. has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient Name: ____

Refused to Sign ______________ Physically unable to sign _________________

(Other) ____

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Employee Signature: __________________________ Date: ___________