

## 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**

**The Health Insurance Portability and Accountability Act of 1996 (HIPAA)** is a federal program that requires that all medical records and other individually identifiable health information be used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significantly new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You *may revoke such authorization in writing* and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations (i.e. work phone instead of home phone).
- The right to inspect and copy your protected health information
- The right to amend your protected health information by using a form provided by our office.
- The right to receive an accounting of disclosures of protected health information
- The right to obtain and we have the obligation to provide you a paper copy of this notice form us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have read our Notice of Privacy Practices, and a copy will be made available to you at your request.

**Daniel Geller Podiatry, PC**  
2001 Santa Monica Blvd., Suite 465W  
Santa Monica, CA 90404  
(310) 395-5025  
[podiatry@drdangeller.com](mailto:podiatry@drdangeller.com)

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint; moreover, our office will make every effort to prevent your privacy protections from being violated.

**Please contact us for more information:**

Daniel Geller Podiatry, PC  
2001 Santa Monica Blvd., Suite 465W  
Santa Monica, CA 90404  
(310) 395-5025

**For more information about HIPAA or to file a complaint:**

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257  
Toll Free: 1-877-696-6775

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**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payers (insurance companies)
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have read your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Dr. Daniel Geller, DPM has the right to change its *Notice of Privacy Practices* from time to time and that I may contact your office during business hours at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that this office is not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME (PLEASE PRINT): \_\_\_\_\_

PARENT/LEGAL GUARDIAN (PLEASE PRINT): \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

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\*

**OFFICE USE ONLY**

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below

Date	Initials	Reason

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