Complete Care Health Services

"Complete, Caring & Affordable Health Care for the New Millenium"

3600 S. Wadsworth Blvd. * Lakewood, CO 80235 * (303) 985-0646

HIPAA NOTICE OF INFORMATION PRACTICES

1. Complete Care Health Services may use and disclosure protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, request i.e. by a 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, Worker's compensation, and general insurance companies for claims including coordination of benefits with other insurers, collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.

2. Complete Care Health Services is permitted or required to use or disclose protected health Information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.

3. Complete Care Health Services will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.

4. Complete Care Health Services may at time contact the patient to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that maybe of interest to the individual patient.

5. Complete Care Health Services will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.

6. Complete Care Health Services 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.

7. Complete Care Health Services will provide each patient with a copy of any revisions of its Notice of Information Practice at the time of their next visit, or at their last known address. 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 offices.

8. 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 above address and/or phone number. All complaints will be addressed and the results will be reported to the (Corporate Compliance Officer/Managing Physician/Board of Directors).

9. It is Complete Care Health Service's 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.

10. The name, title and telephone number of a person in the office to contact for further information (Dr. Kevin Luck, owner, 303-985-0646).

11. The effective date (this cannot be earlier than the date on which the notices is printed or otherwise published).

Consent to the Use and Disclosure of Health Information for Treatment Payment or Healthcare Operations

I understand that as part of my healthcare, Complete Care Health Services originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment, I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence
- of health care professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and that the Practice is not required to agree to the restrictions request. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

- I request the following restrictions to the use of disclosure of my health information.

_____

_____

_____ _____

Signature of Patient or Legal Representative Date

Accepted Denied

_____ _____ _____

Signature Privacy Officer Date

Title

*** Please list any names you wish to authorize access to your account, no information can be shared with anyone not listed on this form. ***

1. _____
2. _____
3. _____