

**Notice of Privacy Practices (HIPPA)**  
**Boston Integrated Health, LLC**  
Erin Walker, Lic. Ac., MAOM

**This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us and we are committed to protecting your personal health information. Every time you visit our center, we create a record of the services and treatment you receive, and this information is recorded in a paper chart and on a computer. We need to maintain your records to provide you with quality care and to comply with legal regulations. Your medical records are the property of this Center but the information in the records belongs to you. This notice also describes your rights and certain duties we have regarding the use and disclosure of medical information.**

**OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect November 1<sup>st</sup>, 2015, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of the notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We may use and disclose health information about you for treatment, payment and healthcare operations.

**Treatment** means providing, coordinating, or managing health care and related services by one or more healthcare providers.

**Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, you may request that we disclose your health information to your insurance provider or third party for the purpose of reimbursement.

**Workers Compensation:** We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

**Healthcare Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, appointment scheduling and customer service. In addition, our center has an open waiting room where patients may be seen by other patients. This area is limited to staff and patients and their healthcare representatives.

**Appointment Reminders:** We may contact you to provide appointment reminders. If you are not available, we may leave a message via email, a voicemail inbox, answering machine or with the person answering your home phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

**Communication with family.** We may need to disclose your health information to a family member in the case of an emergency, in the event you're sick or injured or to the person who is responsible for the payment of your care, in the case of a minor. You will be given the opportunity, if you are present, to agree or object prior to making these disclosures. Any others 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.

**Marketing:** We may contact you to give you information about products or services, case management, care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We do not disclose your personal contact information including your phone number or email address to any third party for marketing or solicitation.

**Required by law:** When the law requires us to report abuse, neglect, domestic violence, we will comply with the relevant legal requirements. We may and are sometimes required by local, state, or federal law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

**Change of Ownership:** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another acupuncturist, physician or medical provider.

**PATIENT RIGHTS: 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.**

**Access:** You have the right to inspect and copy your protected health information.

**Restriction:** You have 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 requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

**Confidential Communications:** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send

information to a particular e-mail account or to your work address. WE will comply with all reasonable communication requests submitted in writing.

**Amendment:** You have a right to request that we amend your health information that you believe is incorrect or incomplete. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

**Disclosure Accounting:** You have the right to receive an accounting of disclosures of protected health information.

### **Questions & Complaints:**

If you want more information about our privacy practices, please contact us. You have recourse if you feel that we have violated your privacy rights. You have the right to file written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

**Privacy Officer:**  
Erin Walker  
581 Boylston Street  
Suite 700B  
Boston, MA 02116  
617-536-5222

**US Department of Health & Human Services**  
Office of Civil Rights  
200 Independence Ave. S.W.  
Washington DC, 20201  
202-619-0257 or 1-877-696-6775

**Boston Integrated Health, LLC  
Privacy Policies Acknowledgement**

I have received, read, and understood Boston Integrated Health’s Privacy Policy Notice. I understand how this health care office and its health care providers may use or disclose my health information. I understand when this health care office may not sue or disclose my health information. I understand my health information rights and understand that the office reserves the right to change the Privacy Policies Notice. I also understand how to place a complaint regarding this Notice and have also been provided the opportunity to review and question the privacy policies of this health care office.

---

Signature of Patient or Authorized Representative

Date