

HIPAA Notice and Privacy Policy

Please review this privacy policy in its entirety, and sign and return the last page (Privacy Policy Acknowledgement and Consent). Please contact our practice with any questions or concerns.

The Krochmal Center for Plastic Surgery maintains confidential information as part of your medical record. Your privacy is a high priority for us, as it is essential that you provide complete and accurate information about your medical history so we can provide the safest and best options for your care. The practice is required by law to maintain the privacy of this confidential information. The following notice describes how your Protected Health Information (PHI) may be used, disclosed, and accessed.

While we are required to abide by the terms of this notice, we may be required to update the provisions of the notice in the future. The current policy will be available on our website, available for review in our office, and available to be mailed to you upon your request.

HIPAA- The Health Insurance Portability and Accountability Act, 2002.

The HIPAA privacy rules dictate how PHI may be used and disclosed. PHI refers to your health history, medical conditions, identifiable demographic information, billing information, and payment methods. For the purposes of this notice “Use” means how we (physicians, staff) share, utilize, and analyze your PHI. “Disclose” means how we share and/or transfer your PHI to other entities such as other medical personnel and institutions, insurance companies, financial companies, our contracted business associates and partners, and yourself.

In order to provide medical services to you, including providing treatment, acquiring payment for those services, and supporting the operations of the practice in general, we may be required to use and disclose your PHI. For instance, to coordinate your treatment with other healthcare entities, we may need to disclose your PHI to acquire or provide necessary information for your care. We may also need to disclose PHI to health insurance plans and financial institutions (e.g. banks, credit card companies, third party payors such as CareCredit, and collection agencies) for insurance coverage and payment for your treatment. To support our practice operations, we may say your name in the office, contact you for appointments, and send electronic or print newsletters and marketing materials. For our contracted business partners, we will have a written contract verifying terms protecting your PHI.

Aside for the purposes of providing patient care, billing and acquiring payment for medical services, and supporting the general operations of the practice, we will not disclose your PHI (unless permitted or required by law) without your written authorization. Some common examples (not an exhaustive list) needed for your written consent would be transfer of your records to another provider, disclosure of your information to your employer.

In some circumstances, if you are not able to provide written authorization for disclosure, but your physician determines, based on his or her professional judgment, that it is in your best interest for that



information to be disclosed to so you are provided with the necessary medical care. In these instances, only the relevant PHI and medical documentation will be transferred for that particular situation. Examples may include emergencies or situations where you cannot be located but care is necessary.

With your authorization, once your PHI is transferred to an entity that is not bound by the HIPAA Privacy Rule, your PHI may not be protected. You may revoke your authorization at any time, in writing. However, any transfer of PHI prior to that revocation request may not be possible to be fully withdrawn from the entities to which your information was disclosed.

When family members, close friends (such as those who accompany you to clinical visits or procedures), and other care-takers are involved in your care, we may disclose PHI and medical information that is relevant for your care in that particular case. If you do not want us to disclose certain information to other people who are involved in your care, please notify our office of your preferences.

Examples of situations where the law dictates we share PHI includes disclosure to a public health authority permitted by law to collect that information, to another person whom may have been exposed to a communicable disease, or government agencies responsible for healthcare regulation, accreditation, benefit programs and reporting of child and elder abuse/neglect. We may also be required by law to disclose your PHI in the course of any judicial or administrative proceeding (for instance, in response to a court order or subpoena) or to assist law enforcement with investigations and mitigating serious and imminent threats to personal or public safety. When we disclose PHI as legally required, we will notify you of that disclosure unless legally obligated to not share that disclosure with you.

We may disclose PHI to the US Food and Drug Administration (FDA), or a person or company required by the FDA to obtain that PHI. Such information is typically used to track adverse events with medication and medical devices.

For care involving Workers' Compensation or similar programs, we may be required to disclose your PHI.

You may submit a written request for instances in which your PHI has been shared with other entities. This is a special request, and does not require us to provide instances of "routine sharing" including for purposes including continuity of medical care, insurance, payment, to yourself or legal representatives that you have designated, or other designees for whom you have provided written authorization.

We periodically conduct research to further the practice of medicine. We will share your PHI with other researchers with your written approval of the research protocol, which may involve an external Institutional Review Board evaluating the research protocol.

You may inspect and obtain copies of your PHI and medical record, including billing information. To personally inspect, obtain copies of your record, or have them transferred to another entity of your choice, you must fill out and sign a "Review or Transfer of Medical Records" form and return it to our office. We will work to provide access to these records within 14 days or as applicable by law. There may be a charge to you for administrative, copying, and postage costs. There may be some circumstances where we may

email: lookinggood@krochmalplasticsurgery.com phone: 312.847.1230 fax: 312.753.3161

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need to withhold your information as required by law, including psychotherapy notes or in circumstances of criminal or civil proceeding. If we make a decision to withhold your records, this you may elect to have this decision reviewed.

In general, we will disclose relevant PHI for coordination of your care to other entities involved in your care (e.g. other providers, insurance companies, etc.). If you would like certain aspects of your PHI withheld, let us know which aspects of your PHI we SHOULD NOT disclose in writing. If you are a minor and do not want your PHI shared with your parents or guardian, submit a written request, and we will review your request and act based on our legal obligations.

We will contact you regarding your medical care using the methods you authorize. In general, confidential communication is shared with you personally through phone discussions or in-office visits. When calling your telephone number and leaving a message, we will identify our office and provide a contact phone number, but will not share PHI or confidential information unless you give us permission to do so (e.g. leaving a message to report test results). If you provide alternative locations for contact, we may need to verify financial and payment information in order to honor that request. If you authorize us to contact you by email, we may include only the PHI relevant to your care for that particular issue for which we need information or clarification. If you authorize text messaging, we may contact you regarding appointment reminders. We will not share PHI over text messaging unless you initiate the text to the physician or staff member (for example, you text to say you are having a fever and the doctor asks you for more information or asks for a picture). Please note that any form of communication, especially electronic communication via text and email, is discoverable by third parties (even if the practice and its physician and staff make reasonable safeguards to prevent this discovery).

If there are aspects of your medical record which you feel to be incorrect or incomplete, please fill out a "Medical Record Correction Request". We will review the request and notify you of our decision to amend. We may not amend the record if we determine that the information presented is accurate and complete. If amended, we will notify you of the change and notify any entities that may rely on that information. If we deny your request to amend your medical record, we will notify you of that reason in writing, and explain the process for including your statement of disagreement with our decision in your medical record for future reference (we may write a response to your statement of disagreement), as well as the process for filing a complaint.

Again, we take your privacy very seriously. If you have a question or concern regarding how your Privacy Rights have been handled, please bring it to our attention by calling, writing, or letting us know in person. We want to hear from you. We will investigate any concerns promptly and take corrective measures to prevent any unauthorized disclosures in the future. In no way will your care be affected by voicing your concerns. If you feel uncomfortable notifying our office of any real or perceived violations, you may contact the Department of Health and Human Services.

Privacy Policy Acknowledgement and Consent

Please review our HIPAA Notice and Privacy Policy.

I have reviewed the HIPAA Notice and Privacy Policy in its entirety, understand its provisions. If I have had any questions or concerns regarding its provisions, I have asked the office staff to clarify its contents.

By signing, below, I indicate that I agree with the provisions of the HIPAA Notice and Privacy Policy of The Krochmal Center for Plastic Surgery, version 09.22.2020. I understand that if I do not agree with the policy, I may be refused care by Dr. Daniel J. Krochmal and the staff of The Krochmal Center for Plastic Surgery.

Patient Name (Print)

Parent or Legal Guardian (Print) if signing for a patient

Signature

Date

Contact Options:

Primary Address (Required): _____

City: _____ State/Province: _____ Zip Code: _____

Email Address: _____

Home Phone: _____ Mobile Phone: _____

Preferred Method of Contact Home Phone Mobile Phone Call or Text Email Address
(we will try this one first, but may try to reach you by the other methods also)

I understand that the practice typically conducts much of its patient communication electronically, including appointment reminders, sending documents, and general patient communication.

I DO or **DO NOT** authorize mobile texting reminder of appointments

I DO or **DO NOT** authorize email communication, including sending necessary documents. Note, if you send us an email and do not wish us to respond electronically, let us know that in the email. Otherwise we will assume you would like us to respond electronically.

The practice sends marketing/promotional materials to physical and electronic addresses on file unless a patient opts out. Note: you may miss information on events and specials if you opt out!

I OPT OUT of marketing/promotional material sent to my:

Primary Address Alternative Address Email Address Mobile Texting

email: lookinggood@krochmalplasticsurgery.com

phone: 312.847.1230

fax: 312.753.3161

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