



Notice of Privacy Practices

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accounting Act of 1996 (HIPPA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO YOUR IDENTIFIABLE HEALTH INFORMATION

(PLEASE REVIEW THIS NOTICE CAREFULLY)

Effective Date of Notice: 07/28/03

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

To summarize, this notice provides you with the following important information:

- How we may use and disclose your identifiable health information
- Your privacy rights in your identifiable health information
- Our obligations concerning the use and disclosure of your identifiable health information

The terms of this notice apply to all records containing your identifiable health information that are created or retained by our practice. We reserve the right to revise or amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. You may request a copy of our most current notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

The Office Manager at 815-758-5508

C. WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS.

The following categories describe the different ways in which we may use and disclose your identifiable health information.

1. **Treatment:** Our practice may use your identifiable health information to treat you. We might use your identifiable health information when ordering a prescription for you. We



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1. may disclose your health information to others upon your approval, who may assist in your care such as your spouse, children or parents.
2. **Payment:** Our practice may use and disclose your identifiable health information in order to bill and collect payment for the services and items you may receive from us. For example we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for your treatment.
3. **Health Care Operations:** Our practice may use and disclose your identifiable health information to operate our business. For example, our practice may use your protected health information to evaluate the quality of care you received from us, or to conduct cost management and business planning activities.
4. **Appointment Reminders:** Our practice may use and disclose your identifiable health information to contact you and remind you of an appointment.
5. **Treatment Options:** Our practice may use and disclose your identifiable health information to inform you of potential treatment options or alternatives.
6. **Disclosure Required by Law:** Our practice may use and disclose your identifiable health information when we are required to do so by federal, state or local law.
7. **Public Health Risks:** Our practice may disclose your identifiable health information to public health authorities that are authorized by law to collect information for the purpose of:
 - maintaining vital records, such as births or deaths
 - reporting child abuse or neglect
 - preventing or controlling disease, injury, or disability
 - notifying a person regarding potential exposure to a communicable disease
 - notifying a person regarding a potential risk for spreading or contracting a disease or condition
 - reporting reactions to drugs or problems with products or devices
 - notifying appropriate government agencies and authorities about the potential abuse or neglect of an adult patient (including domestic violence). We will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
 - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

Health Oversight Activities: Our practice may disclose your identifiable health information to a health oversight agency for activities authorized by law. Oversight activities can include for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.



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1. **Lawsuits and Similar Proceedings:** Our practice may use and disclose your identifiable health information in response to a court or administrative order or if you are involved in a lawsuit or similar proceeding.
2. **Law Enforcement:** We may release identifiable health information if asked to do so by a law enforcement official:
 - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
 - Concerning a death we believe might have resulted from criminal conduct
 - Regarding criminal conduct at our offices
 - In response to a warrant, summons court order, subpoena, or similar legal process

 - To identify/locate a suspect, material witness, fugitive, or missing person
 - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity, or location of the perpetrator).
3. **Deceased Patients:** Our practice may release identifiable health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we may release information in order for the funeral directors to perform their jobs.
4. **Organ and Tissue Donation:** Our practice may release your identifiable health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
5. **Serious Threats to Health or Safety:** Our practice may use and disclose your identifiable health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization that is able to help prevent the threat.
6. **Military:** Our practice may disclose your identifiable health information if you are a member of U.S. or foreign military forces (includes veterans) and if required by the appropriate military command authorities.
7. **National Security:** Our practice may disclose your identifiable health information to federal officials for intelligence and national security activities authorized by law. We also may disclose your identifiable health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
8. **Inmates:** Our practice may disclose your identifiable health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
9. **Worker's Compensation:** Our practice may release your identifiable health information for worker's compensation and similar programs.



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D. YOUR RIGHTS REGARDING YOUR IDENTIFIABLE HEALTH INFORMATION

You have the following rights regarding the identifiable health information that we maintain about you:

1. **Confidential Communications:** You have the right to request that our practice communicate with you about your health related issues in a particular manner or at a certain location. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions:** You have the right to request a restriction in our use or disclosure of your identifiable health information for treatment, payment or our health care operations. Additionally, you have the right to request that we limit our disclosure of your identifiable health information to individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your identifiable health information, you must make your request in writing to the Clinic's Office Manager. Your request must describe in a clear and concise fashion: (a) the information

you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure, or both and (c) to whom you want the limits to apply.

3. **Inspection and Copies:** You have the right to inspect and obtain a copy of the identifiable health information that may be used to make decisions about you, including patient medical records and billing records. You can contact our office manager at 815-758-5508 in order to obtain a copy of your medical records or to view your medical records. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances. You may request a review of your denial. Reviews will be conducted by the Clinic's Corporate Compliance Officer.
4. **Amendment:** You may ask to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Office Manager. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. We may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the identifiable health information kept by or for the practice; (c) not part of the identifiable health information in which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available



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1. to amend the information.
2. **Accounting of Disclosures:** All of our patients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain disclosures our practice has made of your identifiable health information. In order to obtain an accounting of disclosure, you must submit your request in writing to Creative Therapeutics’ Office Manager. All requests for an “accounting of disclosures” must state a time period, which may not be longer than six years and may not include dates before July 28, 2003. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. We will notify you of the charge in advance and you may withdraw your request before you incur any costs.
3. **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Secretary of the Department of Health and Human Services through the Office of Civil Rights, you must file the complaint within 189 days of when you know or should have known that the act occurred. The address and phone number for Office for Civil Rights are listed below:

Office for Civil Rights
U.S. Department of Health &
Human Services
233 N. Michigan Ave, Suite 240
Chicago, Il 60601
Telephone: (312) 886-2359
TDD: (312) 353-5693
FAX: (312) 886-1807

Office for Civil Rights
U.S. Department of Health &
Human Services
200 Independence Avenue,
SW – Room 506-F
Washington, D.C. 20201
Telephone: (800) 368-1019

To file a complaint with our practice, contact our Office Manager, Clinic Director or Lynn Batalden. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

4. **Right to Provide Authorization for Other Uses and Disclosures:** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your identifiable health information for the reasons described in the authorization. Please note we are required to retain records of your care.



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Again, if you have any questions regarding this notice or our health information privacy policies, please contact Creative Therapeutics' Office Manager, Clinic Director or Lynn Batalden at 815-758-5508.



Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Creative Therapeutics, Ltd.'s Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of bills, or in the performance of this facility's health care operations. The Notice of Privacy Practices also describes my rights and Creative Therapeutics' duties with respect to my protected health information.

Creative Therapeutics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Please Print Name of Patient or Personal Representative

Date