HIPPA PRIVACY NOTICE

More Than a Gym
245 Newtown Rd. Suite 102
Plainview, NY 11803

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.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control of your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist, our office staff and others (such as our medical biller) outside of your office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information to a physician if we referred you to him or her for further evaluation and/or treatment.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example: relevant protected health information may be disclosed to the health plan (insurance carrier) in order to obtain approval for continued treatment and/or to obtain payment for services rendered.

Health Care Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, staff training activities, basic-office functional activities. For example: we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use or disclose your protected health information as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include (as required by law): public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, criminal activity, military activity and national security. Under the law we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the law.

Other permitted and require uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time in writing except to the extent that your therapist or therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information under Federal Law. However, you may not inspect or copy the following records: Psychotherapy notes, information complied in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notifications purposes as described in this notice of privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Request must be in writing.

Your therapist is not require to agree to a restriction that you may request. If your therapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another health care professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper coopy of this notice from us. Upon request, even if you have agreed to accept this notice alternative, (i.e. electronically).

You have the right to have your therapist amend your protect health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will proved you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the items of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying your privacy contact of your complaint. ***We will not retaliate against you for filing a complaint.***

This notice was published and becomes effective on/or before December 1, 2014.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this from, please ask to speak with our HIPPA compliance office in person or by phone.

Signature below is only acknowledgement that you have received this notice of our privacy practices.

_____	_____	_____
Printed Patient Name	Signature of Patient or Guardian	Date