HIPAA Notice of Privacy Practices

WOMEN'S HEALTH ASSOCIATES OF WYOMING, P.C.
1125 EAST SECOND STREET
CASPER, WY 82601
(307) 577-4225

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 rights to access and control 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.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our 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 physician'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, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and to treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to a health plan to obtain approval for the hospital admission.

Healthcare options: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Consistent with the Privacy Rule, we may use or disclose your protected health information in the following circumstances without your authorization. These include: as Required by Law, Public Health activities including Communicable Diseases: Health Oversight: Abuse, Neglect, or domestic violence: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Medical Examiners, and Funeral Directors: Organ Donation: Research: Criminal Activity: Military and Veterans Activity and National Security: Workers' Compensation: Correctional Institutions.

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 Privacy Rule.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Written 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 physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights

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

You have the right to inspect and request a copy of your protected healthcare information. You are entitled to inspect and request a copy of your protected health information. However, this right does not extend to psychotherapy notes; information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceedings; and protected health information which is subject to the Clinical Laboratory Improvements Amendments of 1988. A request for a copy of your health information must be IN WRITING.

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 healthcare 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 notification 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. A request to restrict use or disclosure of any part of your protected health information must be IN WRITING.

Your physician is not required to agree to a restriction that you may request. If physician 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 Healthcare 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 copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected 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 provide you with a copy of any such rebuttal. Your statement of disagreement with our denial of your request for amendment must be IN WRITING.

You have the right to receive an accounting of certain disclosures we have made, if any, to your protected health information.

We are required to abide by the terms of this notice, currently in effect. We reserve the right to change the terms of this notice and will inform you by mail of any changes.

Release authorizations. The office's new notice has to say that certain disclosures and uses of patient information require authorization from the patient. Those disclosures include:

— Psychotherapy notes. These are the notes of a mental health professional that are kept separate from the record itself.
— Protected information that the office uses for marketing.
— Any disclosure the office makes that constitutes a sale of the protected information.

Fundraising. The notice has to tell patients they can opt out of getting fundraising communications from the office.

Restricting information releases. The notice has to explain that a patient who pays for a service in full and out of pocket can request that the office not disclose any information about that service to any insurance company. The request has to be in writing and has to identify what information is restricted and what insurance company is not to receive it.

Breach notification. The notice has to say that patients will be notified in writing when a breach in their protected information occurs.

Complaints

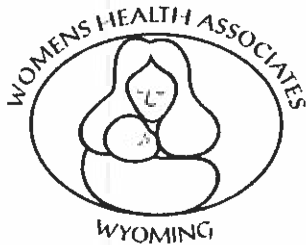
You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. **We sill not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before June 7, 2013

We are required by law to maintain the privacy of protected health information, and provide individuals with notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this, please ask to speak with our HIPAA Compliance Officer in person or by phone at (307) 577-4225.

Signature below is only acknowledgment that you have received a copy of this Notice of our Privacy Practices:

Print Name: ______________________ Signature: ______________________ Date: __________



OBSTETRICS · GYNECOLOGY · INFERTILITY

SAMUEL J. VIGNERI, M.D., F.A.C.O.G.
DIPLOMATE AMERICAN BOARD OF
OBSTETRICS & GYNECOLOGY

CASSIE R. AMADIO, N.P.-C

DATE____________________

NAME________________________________ HOME PHONE____________________

PHYSICAL ADDRESS________________________ BUS. PHONE____________________

MAILING ADDRESS________________________ CELL PHONE____________________

CITY______________________,________,__________ SOCIAL SECURITY #________________

EMPLOYER________________________________ POSITION____________________

DATE OF BIRTH______________ BIRTH PLACE____________________ RACE__________

RELIGION________________________________ MARITAL STATUS________________

INSURANCE COMPANY____

SPOUSE/GUARDIAN/SIGNIFICANT OTHER ______________________ **DOB:**________
SOCIAL SECURITY #____________

EMPLOYER________________________ POSITION______________ PHONE__________

NEAREST RELATIVE OTHER THAN IN YOUR HOME________________**RELATION**________

HOME PHONE______________________ WORK PHONE__________ CELL____________

ADDRESS________________________________ CITY__________ ST______ ZIP________

HAVE YOU BEEN SEEN IN THIS OFFICE BEFORE?____________

IF YOU ARE UNABLE TO KEEP A SCHEDULED APPOINTMENT, PLEASE GIVE OUR OFFICE A 48 HOUR NOTICE TO PREVENT A $50.00 CHARGE.

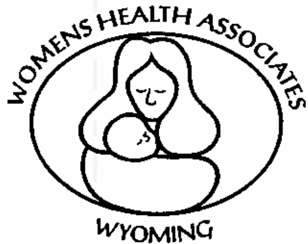
WE WILL BILL YOUR INSURANCE COMPANY. OUR AGREEMENT IS WITH YOU AND NOT YOUR INSURANCE CO SO IF THEY DO NOT PAY YOU WILL RECEIVE A STATEMENT.

PATIENT SIGNATURE____

SIGNATURE OF PERSON RESPONSIBLE FOR BILL____________________ RELATION__________

INSURED'S AUTHORIZED PERSON'S SIGNATURE. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO WOMEN'S HEALTH ASSOCIATES____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM.______________________________



OBSTETRICS · GYNECOLOGY · INFERTILITY

SAMUEL J. VIGNERI, M.D., F.A.C.O.G.
DIPLOMATE AMERICAN BOARD OF
OBSTETRICS & GYNECOLOGY

CASSIE R. AMADIO, N.P.-C

DATE:____________________

NAME:____

REFERRED BY:____________________________________

DO YOU GIVE US PERMISSION TO MAIL A THANK YOU TO ABOVE PERSON_____

PAST HISTORY:

PAST SERIOUS ILLNESS____________________________

SURGERY & DATES: ________________________________

DRUG OR OTHER ALLERGIES OR REACTIONS:__________________

NUMBER OR CHILDREN AND BIRTH DATES:___________________

PREMATURE____________**MISCARRIAGE**__________**STILLBORN**_______

LIST MEDICATIONS YOU NOW TAKE:_______________________

FAMILY HISTORY:

LIST ANY SERIOUS ILLNESS THAT HAS OCCURRED IN YOUR FAMILY(ESPECIALLY DIABETES, MALIGNANCY, HIGH BLOOD PRESSURE, FEMALE DISORDERS OR DIFFICULTIES WITH CHILD BEARING.)____________________________

LIST ALL FEMALE DISORDERS YOU NOW HAVE OR HAVE BEEN TREATED FOR IN THE PAST.____

PROFESSIONAL CORPORATION

1125 EAST SECOND STREET · CASPER, WYOMING 82601 · 307-577-4225