Version Date: 1/2/2012
Effective Date: 01/01/2006

Lung, Asthma and Sleep Associates PC

PRIVACY PRACTICES NOTICE

Effective Date: 01/01/2006

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

If you have any questions or concerns about this notice please contact our privacy officer at:

(717) 848-9888

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **01/01/2006**, 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 medical information that we maintain, including medical 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 this notice.

Who Will Follow This Notice

This notice describes our privacy practices that our physicians and employees will follow to protect your personal protected health information.

Uses and Disclosures of Medical Information

We use and disclose medical information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your medical information to a physician or other health care provider in order to provide treatment to you.

Payment: We may use and disclose your medical information to obtain payment for services we provide to you. We may disclose your medical information to another health care provider or entity subject to the federal and state Privacy Rules so they can obtain payment.

Health Care Operations: We may use and disclose your medical information in connection with our health care operations. These uses are necessary to make sure that all our patients receive quality care. Some examples are:

- Review of our treatment or services to evaluate the performance of our staff providing care;
- Sending you a satisfaction survey;
- Review of information about many of our patients to determine if additional services should be added or perhaps are no longer needed;
- Information may be given to our doctors, nurses, medical and health care students, and other personnel to be sued for education and learning purposes;
- We may remove information that identifies you from the medical information so others may use it for studies in health care delivery without learning who the patients are; and
- We may disclose your medical information to another provider who has a relationship with you and is subject to the same Privacy rules, for their health care operation purposes.

On Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing in any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care of the office.

To Your Family and Friends: Unless you object, we may disclose your medical information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We will also use our professional judgment and our experience with common practice to allow a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of medical information.

By Law or Special Circumstances: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law;
- For public health activities, including disease and vital statistics reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials after receiving subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for the purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To organ procurement organizations;
- To avert a serious health threat or safety
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and nation security activities;
- To correctional institutions regarding inmates; and
- As authorized by state worker's compensation laws.

Health Related Benefits and Services: We may use your medical information to encourage you to purchase or use a product or services or about treatment alternatives that may be of interest to you. We may disclose your medical information to business associate to assist us in these activities. We may use or disclose your medical information to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.

Use and Disclosure of Certain Types of Medical Information: For certain types of medical information we may be required to protect your privacy in ways more strict than we have discussed in this notice. We must abide by the following rules for our use or disclosure of certain types of your medical information or purposes of use or disclosure of your medical information:

- Disclosure of Medical Information for Treatment, Payment Health Care Operations- In order to disclose your medical information in the ways discussed above for treatment, payment and health care operations without specific authorizations, we must obtain your general written permission.
- HIV Information- We may not disclose HIV information unless required by law, pursuant to an authorization or the disclosure is to you or your personal representative; to an agent, employee or medical staff member of a health care provider, when the health care provider has received confidential HIV information during the course of your diagnosis or treatment by the health care provider, provided that the agent, employee or medical staff member is involved in the medical care or treatment of you; to individual health care providers involved in your care with an HIV related condition or positive test, when knowledge of the condition or test result is necessary to provide emergency care or treatment appropriate to you; to health care providers consulted to determine your diagnosis and treatment, to your insurer to the extent necessary so that we may be reimbursed for health care services; to a peer review organization or committee, a nationally recognized accrediting agency or other government oversight bodies that we may legally disclose such information to; to persons whom we know you have had contact with and a physician reasonably believes that there is significant risk of infection to the contact, but only after the physician has attempted to persuade you to disclose to the contact, the physician reasonably believes you will not inform the contact and the physician informs you of his or her intent to disclose the HIV information to the contact.
- Alcohol and Drug Abuse Information. We may not disclose your medical information that contains alcohol and drug abuse information except to you, your personal representative or pursuant to an authorization or as may otherwise be allowed by law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Right to Inspect and Copy: You have the right to look at or get copies of your medical information, with limited exceptions. You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a fee for copying and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

We may deny your request to inspect and copy in very limited circumstances as allowed by law. If you are denied access to your medical information, you may request that the denial by reviewed. Another licensed health care professional chosen by the practice will review you request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities, since April 14, 2003. You must make a request in writing to request a listing of disclosures. You may obtain a form to request the accounting by using the contact information at the end of this notice. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
Restriction: You have the right to request that we place certain restriction on our use or disclosure of your medical information we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions must be in writing. You may obtain a form to request additional restrictions on the use or disclosure of your medical information

by using the contact information listed at the end of this notice. We will not be bound to the restrictions unless our agreement is signed by you and the appropriate office representative.

Confidential Communication: You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. For example, you might request that we contact you at work or by mail. You must make your request in writing. You may obtain a form to request alternative communications by using the contact information listed at the end of this notice. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. Your request must be in writing, and it must explain why the information should be amended. You may obtain a form to request an amendment by using the contact information listed at the end of this notice. We may deny your request if we did not create the information you want amended and the individual who provided the information remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Dr. Charles U. Gbadouwey

Telephone: 717-848-9888 Fax: 717-848-9686

Address: 1497 South Queen Street, York, PA 17403

THIS NOTICE IS YOUR COPY TO RETAIN FOR ANY FUTURE QUESTIONS OR CONCERNS REGARDING THE USE OF YOUR PROTECTED HEALTH INFORMATION.

Please sign the Acknowledgement to signify your receipt and understanding of this document for our records. Thank you.

Lung, Asthma & Sleep Associates, P.C.

1497 South Queen Street
York, PA 17403

419 Village Drive, Suite 5
Carlisle, PA 17015

Financial Policy

If you have medical insurance, with which we participate, we will help you receive your maximum allowable benefit. In order to achieve this, we need your assistance.

Co-payments and co-insurances and for services provided by our practice are due at the time the service is rendered, unless prior arrangements have been made. Our practice accepts, cash, checks, MasterCard, Visa, Discover and American Express. Any balance not paid by your insurance company is due and payable by you within ten (10) business days from receipt of the statement. Any balance ninety (90) days past due may be sent to a collection agency, unless prior arrangements have been made.

We will gladly answer any insurance questions, but insurance plans vary, and we cannot guarantee payment for any service by your insurance company. By signing this policy you agree that your Health Insurance is a contract between you and your insurance company. It is important that you contact your insurance company directly for final guidance and clarification if you have any questions regarding your benefits.

If we participate with your insurance company, all services will be billed to your insurance company, unless we have received prior notification of non-covered services. All deductibles, co-insurances and co-pays are your responsibility. The filing of an insurance claim is a courtesy we extend to all of our patients. Any charges for services performed in our office are ultimately your responsibility. Some plans require referrals and/or authorizations and it is your responsibility to make sure that the referrals and/or authorizations are on file and/or approved.

Please remember that it is also your responsibility to notify our office of any changes in your insurance, including termination PRIOR to any service. Failure to inform our office of a change in insurance could result in patient responsibility for services performed.

If we do not participate with your insurance company, or if you have no insurance, payment is due at the time of service, unless prior arrangements have been made.

Assignment of Benefits/Guarantee of Payment

I hereby authorize and assign benefits and payment directly to Lung, Asthma and Sleep Associates, P.C. for services performed on my behalf and otherwise payable to me. I understand that I am financially responsible for charges not covered by my insurance company.

I acknowledge and agree to endorse any check that may be paid directly to me for the covered service from my insurance company, either in error or because of an insurance policy, and I further agree to return that check to your facility within seven (7) business days. I understand by virtue of the assignment described herein, any funds I receive belong to Lung, Asthma & Sleep Associates, P.C. and that it is UNLAWFUL to use or apply the funds in any other way.

For and in consideration of services performed to the patient named below, I hereby guarantee payment of all charges not paid by insurance together with all necessary collection expenses as set forth above. I have read and understand the financial policy and agree to the terms of this policy. This policy will remain in my records for the future services that may be performed.