NAVARRO COUNTY AMBULATORY CARE ASSOCIATION
Dr. Kent E. Rogers Clinic
618 N Main St., Corsicana, Texas 75110-3028
_903-874-6731 or 903-872-2151

NOTICE OF PRIVACY PRACTICES

Your rights under the Health Insurance Portability Insurance & Accountability Act of 1996 (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

This practice uses and discloses health information about you for treatment and to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies. apply to all the protected health information we maintain.

If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For information about this Notice our privacy practices and policies, please contact the person listed below.

HOW WE MAY USE and DISCLOSE YOUR MEDICAL INFORMATION

Treatment:

We can use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist. When we refer you to that physician, we will send some or all your medical information to that physician to facilitate the delivery of care.

Payment:

We can use and disclose your medical information to bill and collect payment for the services we provide you. For example, we may complete a claim form to obtain payment from Medicare or Medicaid. That form will contain medical information, such as a description. If the medical service provided to you, your insurer must approve payment to us.

Health Care Operations:

We are permitted to use or disclose your medical information for health care operations, which support this practice and ensure quality care is delivered.

For example: Your medical information may be:

1. Reviewed to evaluate the treatment and services performed by our staff in caring for you.
2. Disclosed to physicians, nurses, technicians, healthcare students and other agents of the facility for review and learning purposes.

As Required by Law your medical information will be disclosed when required to do so by federal, state, or local authorities, laws, rules and/or regulations.

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disc ose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Legal Proceedings and Law Enforcement

We may disclose your medical information during judicial or administrative proceedings in response to a court order (or administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

>Information is released pursuant to legal process, such as a warrant, subpoena, and similar lawful process;

> Information requested for information about an actual or suspected crime victim;

> Information pertains to a person who has died under circumstances that may be related to criminal conduct;

>Information is released because of a crime that has occurred on these premises; or

>Information is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

To Alert a Serious Threat to Health or Safety

Your medical information may be used and disclosed when necessary to prevent a serious threat to your health and safety and that of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Health Oversight Activities

Your medical information may be disclosed to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

DISCLOSURES THAT CAN BE MADE WITHOUT WRITTEN AUTHORIZATION

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Workers' Compensation:

We may disclose your medical information as required by state-specific laws regarding workers' compensation claims.

Inmates:

If you are an inmate or under law enforcement's custody, we may release your medical information to the correctional institution or law enforcement official to provide health care for you or the health and safety of others.

Organ Donation, Coroners, Medical Examiners, and Funeral Directors:

Your medical information may be released to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may release medical information about patients to the funeral directors as necessary to carry out their duties.

Public Health Risk, Abuse, and Health Oversight:

Your medical information may be used and disclosed for public health activities. These activities include the following:

>To prevent or control disease, injury, or disability;

> To report child, elderly or disabled person abuse or neglect as required by Texas law.

> To notify a person who may be exposed to a disease or may be at risk of contracting or spreading a disease or condition.

> Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or violence.

INDIVIDUAL RIGHTS UNDER THE PRIVACY REGULATIONS OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996(HIPAA)

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Patient Rights Regarding Your Medical Information:

You have the right to inspect and copy medical information that may be used to make medical decisions about you.

All requests must be submitted in writing. HIPAA permits us to charge a reasonable cost-based fee for all paper copies. We may deny your request to insect and copy in some limited circumstances:

Laboratory results and information that is being complied for in legal action under attorney-client privilege.
If the release of records endangers the life or safety of the patient or another.

If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional, other than the person who denied the request, will be chosen by this facility to review your request and the denial. This facility will comply with the outcome of the reviewed.

Requested Restrictions:

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do not have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (for example, on the use of information, disclosure of information or both), and (c) to whom the limit will apply. Please send the request to the address and the person listed at the end of this notice.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

You have the right to request that a health care item or service not be disclosed to your health care plan for payment purposes or health care operations. We are required to honor your request if the health care service or service is paid out of pocket and in full. This restriction does not apply to use or disclosure of your health information related to your medical treatment.

Right to Amend:

If you feel that medical information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment to information kept by this facility. Except where individual state laws are more stringent. This facility has a minimum of 60 days (about 2 months) to act on your request. Any such request must be made in writing to the person listed at the end of this document. Your request must be in writing, you must provide a reason to support the request. We may refuse to allow an amendment for the following reasons:

Ø Your request is not in writing or does not include a reason to support the request.

Ø the medical information is accurate and complete.

Ø the information is not part of the information you would be permitted to inspect and copy

Ø > The information was not created by this practice or physicians in this practice.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue on your medical record. If the amendment is allowed or denied you will be informed in writing.

Receiving Confidential Communications by Alternative Means:

Appointment Reminders, Treatment Alternatives, and other Benefits

We may contact you by (telephone, mail, or email) to provide appointment reminders, information about alternatives, or other health-related benefits and services.

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed at the end of this notice. We are required to accommodate only a reasonable request. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send to a particular place, the contact/address information.

NCACA provides written/printed materials in English/Spanish. We offer inhouse interpreters for Limited English Proficiency (LEP

ASSIGNMENT OF HEALTH INSURANCE BENEFITS/PROMISE TO PAY:

I hereby assign and authorize payment direct to NAVARRO COUNTY AMBULATORY CARE ASSOCIATION all insurance benefits or proceeds of all claims submitted on my behalf. If eligible for Medicare, I request Medicare assignment of payments to pay NCACA directly for my services. I understand that I am responsible for any charges not covered by my insurance company.

Right to Notice of Breach: You have the right to be notified if we or one of our Business Associates becomes aware of an improper disclosure of your health information.

Changes to this Notice: We reserve the right to change this Notice at any time. We reserve the right to make the revised or changed Notice effective for all health information we have about you as well as any information we receive in the future. We will post a copy of the Notice in the Center. The Notice will contain the effective date. If we amend the Notice, we will offer you a copy of the current Notice in effect. You may request a copy each time that you visit the Center or calling and requesting that a current Notice to be sent to you in the mail.

ELECTRONIC HEALTH RECORD (EHR) and CONSENT TO RELEASE HEALTH INFORMATION:

An electronic health record (EHR) or sometimes called an electronic medical record-allows healthcare providers to record patient information electronically. I understand that electronic medical records contain information about my health from my past, current and future health care providers. I agree that this health information may be released through the Physician/ Health Clinic electronic medical record or by other means (for example), fax, telephone, email, or hard delivery): to past or current health care providers that provide care to me; to the health insurance company named in my medical record; and to any other person named in my medical record who pays for my treatment. I understand these people will have access to all my health information in the medical record, including behavioral health and substance use disorder information, my medical history, diagnosis, hospital records, clinic and doctor visits information, medications, treatments. Allergies and lab tests result in reproductive and sexually transmitted disease. I understand that I may take back this consent at any time, except if my health information has already been released to someone. I understand that I may request a list of health care organizations that have received my health information. This consent will expire one year after my death.

PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING)

I have been made aware and understand that the medical practices and office may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my provider and my pharmacy. I have been informed and understand my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my provider to see this protected health information, prescribed by other providers.

CONSENT FOR VIRTUAL HEALTH/TELEMEDICINE SERVICES: I understand that "virtual health" or "telemedicine services" includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location. The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. I or my authorized representative, hereby give consent to the medical practice/ physicians to engaging in "virtual health or telemedicine services, where available, as part of my treatment.

ADVANCE DIRECTIVE ACKNOWLEDGEMENT:

Federal law requires that patients be provided information about their rights to make advance health care decisions, including Living Will, Durable Medical Power of Attorney or designation of surrogate decision made for health care decisions. If you have already completed any of these documents, please inform your physician and/or the clinic.

Please check one:

__ I have executed an advance directive and have supplied a copy to the Physician/Clinic.
__ I have executed an advance directive and have been requested to supply a copy to the Physician/Clinic.
__ I have reviewed the directives(s) on file with this Physician/Clinic and it is/they are my current directive(s).
__ I have not executed an advance directive; I have received information about advance directives from this Physician/Clinic.

E-MAIL:
I hereby consent to provide my e-mail address, so the representatives from the Physician/Clinic can e-mail information to me about health education or disease prevention and up-to-date information about the Physician/Clinic, its affiliated physicians, and or services. I understand I will be able to change my preference at any time.

Cell Phones:
I hereby consent to provide my telephone number(s), so that representatives from the Physician/Clinic, can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or e-mailing, regarding any matter, including but not limited to my medical treatment. Prescriptions, insurance eligibility, insurance coverage, scheduling, billing, or collection matters. This consent includes any updated or additional contact information that I may prove. I understand that I will be able to change my preference at any time.

General Consent for Tests, Treatment, and Services.
I have been informed of the treatment procedures considered necessary for me and that the treatment procedures will be directed by a physician or Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical staff.
Notice of Privacy Practices:
Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of NCACA Clinic Notice of Privacy Practices. I hereby consent to the use of and disclosure of my protected health information, including information generated through virtual health/telemedicine services, as described in this Notice of Privacy Practices. Including treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, and genetic testing. And other types of treatment received.

VIDEOTAPING/ RECORDING:
I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging and sounds on any devise. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

NON-DISCRIMINATION: Navarro County Ambulatory Care Association complies with the state and federal anti-discrimination laws, including and without limitation:
Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act of 1990, Age Discrimination Act of 1975, Education Amendments of 1972, and administrative rules for HHS agencies, as forth in the Texas Administrative Code (TAC).

Navarro County Ambulatory Care Association will not discriminate based on race, color, national origin, including Limited English Proficiency (LEP), Sex, Age, Religion, Disability, or Sex Orientation.

Inspection and copies of Protected Health Information: You have a right to a copy of this notice.

Our Promise to You:

You will not be penalized for filing a complaint. If you believe your privacy rights have been violated, you may file a complaint with this facility or the Secretary of the Department of Health and Human Services. To file a complaint against the facility, contact the Facility Privacy Officer. All complaints must be in writing.

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests:
If you have any questions or want to make a request pursuant to the rights described above, please contact:

Janquilyn Merida, DNP, APRN, FNP-C, Clinical Director
618 N Main St.
Corsicana, Texas 75110-3028
T903-872-215[illegible] or 903-874-6731

This Notice is effective April 14, 2023