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Natural Health Care

Notice of Privacy Practices

Effective as of June 1st, 2018



Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR NATUROPATHIC AND ACUPUNCTURE INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Use and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1. Your naturopath and acupuncturist, or a staff member, may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2. Our billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, and automotive insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3. Your naturopath and acupuncturist, and members of the staff, may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.
4. Your naturopath and acupuncturist, and members of the practice staff, may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left of your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

Permitted Uses and Disclosures Without Your Consent or Authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

5. To the extent that we are required to do so by applicable federal or state laws.
6. A public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information under state or federal law.
7. To an appropriate government authority if we reasonably believe you are the victim of abuse, neglect or domestic violence.
8. For state and federal health oversight activities of the health care system and government benefit programs.
9. In response to a court order or, in response to a subpoena, discovery request, or other lawful purpose.
10. To provide information to a law enforcement official as required by laws that require us to report certain types of wounds or physical injuries or, to comply with court orders, a grand jury subpoena, or administrative requests authorized by the law.
11. To an appropriate law enforcement authority if the disclosure is necessary to prevent or lesson a serious and immanent threat to the health or safety of a person or the public.
12. A correctional institution if we provide health care services to you as an inmate.
13. If we provide health care services to you in an emergency.
14. If we provide care to you that is related to a work place injury to the extent necessary to comply with Washington's worker's compensation laws.

Other than the circumstances described in the preceeding examples, any other use or disclosure of your health information will only be made with your written authorization.



Your Right To Revoke Your Authorization

You may revoke your authorization to us at any time ; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization.
2. If you were required to give your authorization if they decide to contest any of your claims.

Your Right To Limit Uses Or Disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. Salmon Creek Clinic honors patient's requests, when applicable.

Your Right To Receive Confidential Communication Regarding Your Health Information

We normally provide information about your health to you in person at the time you receive naturopathic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your Right To Inspect And Copy Your Health Information

You have the right to inspect and/or copy your health information for (7) seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing. We may refuse your request if the information is for use in a civil, criminal or administrative action or proceeding which is anticipated to occur in a time frame reasonable proximate to your request. There may be a cost associated with your request if we must copy information for you.

Your Right To Amend Your Health Information

You have the right to request that we amend your health information for (7) seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your Right To Receive An Accounting Of The Disclosures We Have Made Of Your Records

You have the right to request that we give you an accounting of the disclosures we have made of your health information to the last (6) years before the date of your request. The accounting will include all disclosures except the following:

1. Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
2. Those disclosures made to you.
3. Those disclosures we are permitted to make without your consent or authorization as described above.
4. Those disclosures made based on an authorization you signed.
5. Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
6. Those disclosures for national security or intelligence purposes.
7. Those disclosures made to correctional officers or law enforcement officers.
8. Those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months.



Your Right To Obtain A Paper Copy Of This Notice

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our Duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices in respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms, the change will apply for all of your health information in our files.

Re-Disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. We are not liable for 3rd party re-distribution of information.

Your Right To Complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be sent to us at the address listed below.

To Contact Us

If you would like further information about our privacy policies and practices please contact:

Dr. Jared Zeff N.D., L.Ac.
Salmon Creek Clinic
3606 Main St.
Suite #201
Vancouver, WA 98663
Ph.: (360) 823-8121

This notice is effective as of June 1st, 2018. This notice will expire (7) seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

Patient Name Printed

Date

Patient Signature

Authorized SCC Representative

Personal Representative Printed

Personal Representative Signature

Description Of Personal Representative's Authority To Act For The Patient.