American Vein & Vascular Institute

HIPAA NOTICE OF PRIVACY PRACTICES

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American Vein and Vascular Institute- Headquarters
9960 Federal Drive, Suite 160 Colorado Springs, CO 80921

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

For purposes of this Notice "us" "we" and "our" refers to American Vein and Vascular Institute ("American Vein") (on behalf of itself and its affiliated entities)[1] and "you" or "your" refers to our patients (or their legal representatives as determined by us in accordance with state informed consent law). When you receive health-care services from us, we will obtain access to your medical information from other care providers. We are committed to maintaining the privacy of your health information.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA), as amended by the HITECH Act and the HIPAA Final Omnibus Rules, is a federal law that requires us to maintain the confidentiality of all your healthcare records and other individually identifiable health information used by or disclosed to us in any form, whether electronically, on paper, or orally. To the extent this information individually identifiable it is referred to under HIPAA as Protected Health Information or PHI. HIPAA gives you significant new rights to understand and control how your health information is used. HIPAA and state law provide penalties for covered entities and records owners, respectively, that misuse or improperly disclose PHI. As required by regulations under HIPAA, we have prepared this explanation of how we will maintain the privacy of your health information and how we may use and disclose your health information.

Our doctors, clinical staff, Business Associates (outside contractors we hire), employees and other office personnel follow the policies and procedures set forth in this Notice. If your American Vein provider is unavailable to assist you, we may provide you with the name of another American Vein provider to consult with. If your provider shares call with an outside group that provider will follow the policies and procedures set forth in this notice or those established for his or her practice, so long as they substantially conform to those for our practice.

Under the law, we must have your signature on a written, dated Consent form and/or an Authorization form before we will use and disclose your health information for certain purposes as detailed in the rules below.

You will be asked to sign a Consent / Authorization form when you receive this Notice of Privacy Practices. If you did not sign such a form or need a copy of the one you signed, please contact our Privacy Officer. You may take back or revoke your consent or authorization at any time (unless we already have acted based on it) by submitting our Revocation form in writing to us at our address listed above. Your revocation will take effect when we actually receive it. We cannot give it retroactive effect, so it will not affect any use or disclosure that occurred in our reliance on your Consent or Authorization prior to revocation (e.g., if after we provide services to you, you revoke your authorization or consent in order to prevent us billing or collecting for those services, your

[1] American Vein and Vascular is the dba for Rocky Mountain Vein Institute. This Notice of Privacy Practices may be updated from time to time to reflect additional affiliated companies.

revocation will have no effect because we relied on your authorization or consent to provide services before you revoked it).

If you do not sign our Consent form or if you revoke it, as a general rule (subject to exceptions described below), we cannot in any manner use or disclose to anyone (excluding you, but including insurance companies and Business Associates) your health information or any other information in your medical record. By law, we are unable to submit claims to insurance companies under assignment of benefits without your signature on our Consent form. We will not condition treatment on your signing an Authorization, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the Consent or revoke it.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We typically use or share your health information in the following ways:

• **Your Treatment.**
We can use and disclose your health information to provide you with health care treatment or coordinate health-care treatment and services with other professionals who are treating you. For example, we may review your health history to form a diagnosis and treatment plan, consult with other doctors about your care, delegate tasks to staff, call in prescriptions to your pharmacy, or schedule lab work for you.

• **To Pay for Your Health Services.**
We can use and disclose your health information as we pay for your health services. For example, we may need to verify your insurance coverage, submit your health information on claim forms in order to get reimbursed for our services from insurance companies or managed care organizations, obtain pre-treatment estimates or prior authorizations from your health plan.

• **Run Our Organization.**
We can use and disclose your health information to run our organization and contact you when necessary and provide you with customer service. For example, to improve efficiency and reduce costs associated with missed appointments, we may contact you by telephone, mail or otherwise remind you of scheduled appointments we may call you by name from the waiting room, we may ask you to put your name on a sign-in sheet, or we may tell you about or recommend health-related products and complementary or alternative treatments that may interest you. If you prefer that we not contact you with appointment reminders or information about treatment alternatives or health-related products and services, please notify us in writing at our address listed below this paragraph and we will not use or disclose your health information for these purposes.

American Vein and Vascular
Institute 9960 Federal Drive, Suite
160 Colorado Springs, CO 80921
Attn: Privacy Officer

OTHER USES AND DISCLOSURES

We are allowed, and in some instances required, to share your health information in other ways that are usually in ways that contribute to the public good--such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. Examples of such other uses and disclosures include:

• *Comply with the Law*.

• *Help with Public Health and Safety Issues*.

For example:

- When necessary to prevent a serious threat to anyone's health and safety
- Prevention or control of disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect or exploitation of children, disabled adults or the elderly, or domestic violence

• *For Law Enforcement and other Government Requests.*

For example:

- For law enforcement purposes (e.g., a warrant) or with a law enforcement official
- With health oversight agencies for activities authorized by law such as investigations and audits
- For special government functions such as military, national security and presidential protective services

• *To Respond to Lawsuits and Legal Actions*.

For example:

- In response to a subpoena or court order

To Respond to Organ/Tissue Donation Requests or Work with a Medical Examiner or Funeral Director.

For example:

- Share information with coroners, medical examiners and funeral directors when an individual dies
- Share with organizations that handle organ, eye or tissue procurement, donation and transplants

• *For Workers' Compensation purposes*.

For example:

- If you have claimed health benefits for a work-related injury or illness

• *Do Research*.

For example:

- Health research projects approved by an Institutional Review Board

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, let us know. Tell us what you want to do, and we will follow your instructions.

In the following cases, you have both the right and choice to tell us to:

- Share information with family members, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising purposes

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we feel it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. The following are examples for you to keep in mind:

- We give you an opportunity to object to our sharing information with another party in your presence and if you do not, we reasonably assume, based on our professional judgment and the surrounding circumstances, that you do not object (e.g., you bring someone with you into the operating or exam room during treatment or into the conference area when we are discussing your health information).
- It is an emergency situation involving you and you cannot consent to care because you are unconscious.
- It is an emergency situation involving another person (e.g., your minor child) and you cannot consent to care because we have been unable to locate you after a reasonable attempt.

In the following cases, we will NEVER share your information unless you give us written permission (except to the extent we are required to do so under the law as noted above):

- Marketing purposes
- Sale of your information
- Sharing of psychotherapy notes
- Sharing of sensitive health information such as HIV testing, alcohol or substance abuse diagnosis and treatment

In the foregoing instances, you can provide us with your authorization to share such information by completing our Consent form where you must specifically initial the type of sensitive information you are authorizing us to disclose.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your medical information:

To Inspect and Copy

You have the right to obtain an electronic or paper copy of your medical record. We will provide you with a copy or, upon request, with a summary of your medical record and other health information that we have about you. You can obtain your copies or summary by submitting a written request to our Privacy Officer on our Request to Inspect, Copy, or Summarize form.

Please keep in mind that we have the right to charge a reasonable fee for copies to recover the costs we incur in preparing your copies or summary. We will, under no circumstances, condition the release of your information (whether copies or summary format) on the payment of your outstanding balance for professional services (if you have one).

We will typically provide a copy of your medical information or a summary (if requested) in thirty days or less for requests that are submitted in writing and that include all relevant information. If you

have an urgent situation and need the information on an expedited basis please include the reason for the expedited request when submitting your initial request.

To Correct Your Medical Record
If you think your information in the medical record we are maintaining is inaccurate or incomplete, you can request that your information be corrected by submitting a written request yourself or by asking one of your treating physicians to do so on your behalf. If you decide to submit the request yourself, please submit the request via our Request for Amendment / Correction form and send it to the attention of our Privacy Officer.

We normally will act on your request within 60 days from receipt, however, if we determine that it may take additional time, we will notify you in writing that it may take up to an additional 30 extra days. We will confirm for you in writing if we make the requested correction and will send a copy of the correction to others as you may request in writing.

We may deny your request under certain circumstances (e.g., it is not in writing, you have not provided an explanation for the correction, the medical information did not originate with us). If we deny your request, we will tell you why in writing and provide information if you wish to appeal our decision.

To Request Alternative Communications
You may ask us to communicate with you in a different way or at a different place by submitting a written Request for Alternative Communication form to us. We will not ask you why and we will accommodate all reasonable requests (which may include: to send appointment reminders in closed envelopes rather than by postcards, to send your medical information to a post office box instead of your home address, to communicate with you at a telephone number other than your home number).

To Request Restrictions
You may ask us to limit how your medical information is used or shared for treatment, payment or operational purposes by submitting a written Request for Restrictions on Use, Disclosure form to our Privacy Officer. Examples of when you might want to make sure requests include instances where you do not want us to disclose your surgery to family members or friends involved in paying for our services or providing your home care. We are not required to agree to your request and may decline if we agreeing to such request would affect your care. We will notify you in writing if we make such an election.

To Get an Accounting of Disclosures
You may ask us for us to provide you with a list of those who received your medical information from us by submitting a Request for Accounting of Disclosures form. The request should be made to our Privacy Officer. We will include all disclosures except for those about treatment, payment and health care operations or disclosures that you asked us to make (e.g., to your legal representative).

Your request must state in what form you want the list (e.g., paper or electronic) and the time period you want us to cover, which may be up to but not more than the last six years from the date of your written request. If you ask us for this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee to respond, in which case we will tell you the cost before we incur it and let you choose if you want to withdraw or modify your request to avoid the cost.

To Get a Copy of this Privacy Notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

To Choose Someone to Act for You
You have the right to provide someone with a medical power of attorney to make healthcare decisions on your behalf subject to the terms of such medical power of attorney. Also, if someone

has been appointed your legal guardian they too have the right to make decisions about your healthcare. In such instances, we will validate the delegations or designations before taking any action.

To File a Complaint or Get More Information

If you want more information or you believe your privacy rights have been violated, you can request additional information or file a complaint by submitting a written request for information or by sending a Complaint form to us at the following address:

American Vein and Vascular Institute
9960 Federal Drive, Suite 160 Colorado
Springs, CO 80921
Office Phone: 719-766-8346
Office Fax: 800-276-7170
Attn: Compliance Officer
Email Address:
[_info@americanvein.com_]

Or to the U.S. Department of Health & Human Services via the following:

By mail:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201

By calling:

877.696.6775

By internet:

www.hhs.gov/ocr/privacy/hipaa/complaints

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Effective Date and Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. The effective date of this Notice is **May 3, 2019**.