

**PT PLUS, P.C.**  
**NOTICE OF PRIVACY PRACTICES**

Effective Date: April 14, 2003

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.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our physical therapy office and its staff. A copy of our current notice will always be posted in our reception area. You will also be able to obtain your own copies by accessing our website at [www.pt-plus.org](http://www.pt-plus.org), by calling our office, or by asking anyone on staff for one at the time of your next visit.

If you have any questions about this notice or would like further information, please contact Marijeanne Liederbach at (212) 246-3700.

**WHO WILL FOLLOW THIS NOTICE?**

- ▶▶ Any PT Plus health care professionals who treat you;
- ▶▶ All PT Plus employees, students and volunteers;

**PERMISSIONS DESCRIBED IN THIS NOTICE**

This notice will explain the different types of permission we will obtain from you before we use or disclose your health information for a variety of purposes. The three types of permissions referred to in this notice are:

▶▶ A “general written consent,” which we must obtain from you in order to use and disclose your health information in order to treat you, obtain payment for that treatment, and conduct our business operations. We must obtain this general written consent the first time we provide you with treatment or services. This general written consent is a broad permission that does not have to be repeated each time we provide treatment or services to you.

▶▶ An “opportunity to object,” which we must provide to you before we may use or disclose your health information for certain purposes. In these situations, you will have an opportunity to object to the use or disclosure of your health information in person, over the phone, or in writing.

▶▶ A “written authorization,” which will provide you with detailed information about the persons who may receive your health information and the specific purposes for which your health information may be used or disclosed. We are only permitted to use and disclose your health information described on the written authorization in ways that are explained on the written authorization form you have signed. A written authorization will have an expiration date.

**IMPORTANT SUMMARY INFORMATION**

**Requirement For Written Authorization.** We will obtain your written authorization before using your health information or sharing it with others outside the practice. You may also initiate the transfer of your records to another person by completing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it.

## **Exceptions To Written Authorization Requirement.**

There are some situations when we do not need your written authorization before using your health information or sharing it with others. They are:

▶▶**Exception For Treatment, Payment, And Business Operations:** We will only obtain your general written consent one time to use and disclose your health information to treat your condition, collect payment for that treatment, or run our business operations. In some cases, we also may disclose your health information to another health care provider or payor for its payment activities and certain of its business operations as permitted by law.

▶▶**Exception For Patient Directory And Disclosure To Family And Friends Involved In Your Care:** We will ask you whether you have any objection to including information about you in our internal quality assurance and improvement analyses or sharing information about your health with your friends and family involved in your care as permitted by law.

▶▶**Exception In Emergencies Or Public Need:** We may use or disclose your health information in an emergency or for important public needs. For example, we may share your information with public health officials at the New York State or City Health Departments who are authorized to investigate and control the spread of diseases as permitted by law.

▶▶**Exception If Information Is Completely Or Partially De-Identified:** We may use or disclose your health information if we have removed any information that might identify you so that the health information is “completely de-identified.” We may also use and disclose “partially de-identified” information if the person who will receive the information agrees in writing to protect the privacy of the information as permitted by law.

## **How To Access Your Health Information:**

You have the right to inspect and copy your health information.

## **How To Correct Your Health Information:**

You have the right to request that we amend your health information if you believe it is inaccurate or incomplete.

## **How To Identify Others Who Have Received Your Health Information:**

You have the right to receive an “accounting of disclosures,” which identifies certain persons or organizations to whom we have disclosed your health information in accordance with the protections described in this Notice of Privacy Practices.

## **How To Request Additional Privacy Protections:**

You have the right to request further restrictions on the way we use your health information or share it with others. We are not required to agree to the restriction you request, but if we do, we will be bound by our agreement.

## **How To Request More Confidential Communications:**

You have the right to request that we contact you in a way that is more confidential for you, such as at home instead of at work. We will try to accommodate all reasonable requests.

## **How Someone May Act On Your Behalf:**

You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the

privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

### **How To Learn About Special Protections For HIV, Alcohol and Substance Abuse, Mental Health And Genetic Information:**

Special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you will be provided with separate notices explaining how the information will be protected.

### **How To Obtain A Copy Of This Notice:**

You have the right to a paper copy of this notice. You may request a paper copy at any time, even if you have previously agreed to receive this notice electronically. To do so, please call Marijeanne Liederbach at (212) 246-3700. You may also obtain a copy of this notice from our website at [www.pt-plus.org](http://www.pt-plus.org), or by requesting a copy at your next visit.

### **How To File A Complaint:**

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact Marijeanne Liederbach at (212) 246-3700. *No one will retaliate or take action against you for filing a complaint.*

### **WHAT HEALTH INFORMATION IS PROTECTED**

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- ▶▶ information indicating that you are a patient at PT Plus, P.C. or receiving treatment or other health-related services from our practice;
- ▶▶ information about your health condition (such as a disease you may have);
- ▶▶ information about health care products or services you have received or may receive in the future (such as an operation); or
- ▶▶ information about your health care benefits under an insurance plan (such as whether a prescription is covered), when combined with:
  - ▶▶ demographic information (such as your name, address, or insurance status);
  - ▶▶ unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); and
  - ▶▶ other types of information that may identify who you are.

### **HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION**

#### **Treatment, Payment And Business Operations**

With your general written consent, we may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run our business operations. In some

cases, we may also disclose your health information for payment activities and certain business operations of another health care provider or payor.

**Emergencies.** We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your general written consent. If this happens, we will try to obtain your general written consent as soon as we reasonably can after we treat you.

**Communication Barriers.** We may use and disclose your health information if we are unable to obtain your general written consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

**As Required By Law.** We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

**Public Health Activities.** We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury or disability. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits us to do so. And finally, we may release some health information about you to your employer if your employer hires us to provide you with a physical exam and we discover that you have a workrelated injury or disease that your employer must know about in order to comply with employment laws.

**Victims Of Abuse, Neglect Or Domestic Violence.** We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of such abuse, neglect or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

**Health Oversight Activities.** We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

**Product Monitoring, Repair And Recall.** We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

**Lawsuits And Disputes.** If you are involved in a lawsuit, claim, potential claim, or dispute, we may disclose medical information about you to your attorneys, investigators, and insurance companies representing the interests of or insuring **our physical therapy office and its staff**. We may also disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may disclose your health information to law enforcement officials for the following reasons:

- ▶▶ To comply with court orders or laws that we are required to follow;
- ▶▶ To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
- ▶▶ If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your general written consent because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
- ▶▶ If we suspect that your death resulted from criminal conduct;
- ▶▶ If necessary to report a crime that occurred on our property; or
- ▶▶ If necessary to report a crime discovered during an offsite medical emergency (for example, by emergency medical technicians at the scene of a crime).

**Workers' Compensation.** We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

**Research.** In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may use and disclose your health information without your written authorization if we obtain approval through a special process to ensure that research without your written authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your written authorization to people who are preparing a future research project, so long as any information identifying you does not leave our facility. In the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

### **Completely De-identified Or Partially De-identified Information**

We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" health information about you if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will *not* contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

### **Incidental Disclosures**

While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

## **YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION**

We want you to know that you have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information we have about you is accurate. They may also help you control the way we use your information and share it with others, or the way we communicate with you about your medical matters.

### **Right To Inspect And Copy Records**

You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to PT Plus, P.C.. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. The standard fee is \$0.75 per page and must generally be paid before or at the time we give the copies to you. We will respond to your request for inspection of records within 10 days. We ordinarily will respond to requests for copies within 30 days if the information is located in our facility, and within 60 days if it is located off-site at another facility. If we need additional time to respond to a request for copies, we will notify you in writing within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request.

### **Right To Amend Records**

If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records. Your request should include the reasons why you think we should make the amendment. Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request. If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement which we will include in your records. We will also include information on how to file a complaint with us or with the Secretary of the Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

### **Right To An Accounting Of Disclosures**

After April 14, 2003, you have a right to request an “accounting of disclosures” which identifies certain other persons or organizations to whom we have disclosed your health information in accordance with applicable law and the protections afforded in this Notice of Privacy Practices. An accounting of disclosures does not describe the ways that your health information has been shared within and between our physical therapy office and its staff, as long as all other protections described in this Notice of Privacy Practices have been followed (such as obtaining the required approvals before sharing your health information with our doctors for research purposes). An accounting of disclosures also does not include information about the following disclosures:

- ▶▶ Disclosures we made to you or your personal representative;
- ▶▶ Disclosures we made pursuant to your written authorization;
- ▶▶ Disclosures we made for treatment, payment or business operations;
- ▶▶ Disclosures made from the patient directory;

- ▶▶ Disclosures made to your friends and family involved in your care or payment for your care;
- ▶▶ Disclosures that were incidental to permissible uses and disclosures of your health information (for example, when information is overheard by another patient passing by);
- ▶▶ Disclosures for purposes of research, public health or our business operations of limited portions of your health information that do not directly identify you;
- ▶▶ Disclosures made to federal officials for national security and intelligence activities;
- ▶▶ Disclosures about inmates to correctional institutions or law enforcement officers;
- ▶▶ Disclosures made before April 14, 2003.

To request an accounting of disclosures, please write to Marijeanne Liederbach at 130 West 56<sup>th</sup> Street, Ste 6M, NY, NY, 10019. Your request must state a time period within the past six years (but after April 14, 2003) for the disclosures you want us to include. For example, you may request a list of the disclosures that we made between January 1, 2004 and January 1, 2005. You have a right to receive one accounting within every 12 month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12 month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred. Ordinarily we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting. In rare cases, we may have to delay providing you with the accounting without notifying you because a law enforcement official or government agency has asked us to do so.

### **Right To Request Additional Privacy Protections**

You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, or run our business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. For example, you could request that we not disclose information about a surgery you had. Your request should include: (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply. We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction.

### **Right To Request Confidential Communications**

You have the right to request that we communicate with you about your medical matters in a more confidential way by requesting that we communicate with you by alternative means or at alternative locations. For example, you may ask that we contact you at home instead of at work. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests. Please specify in your request how or where you wish to be contacted, and how payment for your health care will be handled if we communicate with you through this alternative method or location.

## ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by our physical therapy office and its staff and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information and genetic information.

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Signature of Patient or Personal Representative

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Print Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority