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## NOTICE OF PRIVACY PRACTICES

***This notice describes how medical information about you may be used and/or disclosed, and how you may access this information. Please review it carefully. The privacy of your information is important to us.***

This Notice of Privacy Practices describes how Dr. Lisa M. Hunsicker and Revalla Plastic Surgery may use and/or disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. "Protected Health Information" is the information about you, including demographic information that may identify you and that is related to your past, present or future physical or mental health condition and related health care services. This notice also describes your rights to access and control your Protected Health Information.

We are required to abide by the terms of the Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be in effect for all protected health information that we maintain at that time. If the notice changes, you may contact us and request that a revised copy be sent to you in the mail or you may ask for one at the time of your next appointment.

### **1. Uses & Disclosures of Protected Health Information**

You will be asked to sign a consent that allows the use and disclosure of your protected health information for treatment, payment, and health care operations. Your protected health information may be used and disclosed by Dr. Lisa M. Hunsicker and the Revalla Plastic Surgery staff, and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of Revalla Plastic Surgery, and any other use required by law.

Following are examples of the types of uses and disclosures of your Protected Health Information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but describe the types of uses and disclosures that may be made by the office.

**Treatment:** We will use and disclose Protected Health Information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health information with a third party. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your Protected Health Information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant Protected Health Information be disclosed to the health plan to obtain approval for the hospital admission.

**Health Care Operations:** We may use or disclose, as needed, your Protected Health Information in order to conduct day-to-day activities, certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we disclose your Protected Health Information to medical school interns that see patients at our office. In addition, we may use a sign-in-sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when Dr. Hunsicker is ready to see you. We may use or disclose your Protected Health Information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We may also share your Protected Health Information with third party "Business Associates" that perform various activities such as billing and transcription services for our practice. Whenever possible, an arrangement is made with the "Business Associate" to ensure your Protected Health Information will be protected.

**Other Permitted and Required Uses and Disclosures:** Other uses of your Protected Health Information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

Unless you object, we will disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to the personal involvement of your care. If you

are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional opinion.

Unless you object, we may use or disclose your Protected Health Information, as necessary, to provide you with information about treatment alternatives or other health-related benefits or services that may be of interest to you. We may also use and disclose your Protected Health Information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information on products or services that we believe may be beneficial to you. You may opt out of receiving further such information by contacting our office.

We may also use or disclose your Protected Health Information in the following situations without your authorization. These situations include: As Required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse & Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, and Required Uses and Disclosures.

**You may revoke this authorization** at any time in writing. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

## **2. Patient Rights**

Following is a statement of your rights with respect to your Protected Health Information.

**You have the right to inspect and copy your Protected Health Information.** Under federal law you may inspect or copy your Protected Health Information, except for the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to Protected Health Information.

**You have the right to request a restriction of your Protected Health Information.** This means you may ask us not to use or disclose any part of your Protected Health Information for the purposes of treatment, payment, or health care operations. You may also request that any part of your Protected Health Information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Dr. Hunsicker is not required to agree to a restriction that you may request. If Dr. Hunsicker believes it is in your best interest to permit use and disclosure of your Protected Health Information, your Protected Health Information will not be restricted. You then have the right to use another healthcare professional.

**You may have the right to have your physician amend your Protected Health Information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an account of certain disclosures we have made, if any, of your Protected Health Information.** This right applies to disclosure for purposes other than treatment or payment or health care operations as described in this notice. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**

**You have the right to obtain a paper copy of this notice from us upon request,** even if you have agreed to accept this notice electronically.

For any questions regarding or in invoking your rights, you may contact our office at 720-283-2500.

## **3. Complaints**

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

**Revalla Plastic Surgery  
7750 S. Broadway, Suite 150  
Littleton, CO 80122**

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address above. In addition you may

complain to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You will not be penalized or otherwise retaliated against for filing a complaint.

**Contact Persons:** The name & address of the person you can contact for further information concerning our privacy practices is the office staff at Revalla Plastic Surgery or Dr. Lisa M. Hunsicker herself at:

**Revalla Plastic Surgery**  
**7750 S. Broadway, Suite 150**  
**Littleton, CO 80122**  
**Phone#: (720) 283-2500**

*This notice took effect on or after 04/14/03 and was revised on 04/05/06*

**Revalla Plastic Surgery**  
**Lisa M. Hunsicker, MD, FACS**  
7750 S. Broadway, Suite 150 • Littleton, CO 80122  
Phone (720) 283-2500 • Fax (720) 283-1122

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_  
Last Name First Name Initial

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

The Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a Patient Rights section describing your rights under law. Please review this Notice before signing this form. The terms of our Notice may change. You may obtain a copy of this Notice at any time by contacting our office. Your privacy is very important to us and we strive to maintain confidentiality throughout our normal course of business.

I acknowledge that I have been provided the opportunity to read and understand the Notice of Privacy Practices from Revalla Plastic Surgery and Dr. Lisa M. Hunsicker.

I consent to the use or disclosure of my Protected Health Information by Dr. Lisa M. Hunsicker and the Revalla Plastic Surgery staff for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, and to conduct health care operations. You may revoke this consent in writing and signed by you. However, such a revocation shall not affect any disclosures we have already made based on your prior consent.

I understand that it may be necessary for Dr. Lisa M. Hunsicker and/or the Revalla staff to use a variety of methods to communicate with me which may include providing information to those who accompany me to appointments and/or procedures, leaving voice messages regarding appointments and/or sending email. I acknowledge that all medical communications carry some level of risk and that online communication is particularly vulnerable to interception by unintended recipients.

- I understand that I have a right to:
- Inspect and copy my Protected Health Information,
  - Request a restriction of my Protected Health Information,
  - Request to receive confidential communication from us by alternative means or at alternative location,
  - Obtain a paper copy of this notice from us
  - Request my physician amend my Protected Health Information and
  - Receive an account of certain disclosures we have made, if any, of my Protected Health Information.

I understand that Revalla Plastic Surgery reserves the right to modify the privacy practices outlined in the Notice.

\_\_\_\_\_ Date \_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_ Date \_\_\_\_\_  
**Signature and Printed Name of Patient Representative/Guardian (if applicable) and relationship**

\_\_\_\_\_ Date \_\_\_\_\_  
**Signature of Staff Witness**

\_\_\_\_\_ Date \_\_\_\_\_  
**Signature of Physician**  
**Lisa M. Hunsicker, MD, FACS**