

## **Dupont Circle Physicians Group Health Information Privacy Policy Insurance Billing Authorization**

THIS AUTHORIZATION DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IT ALSO GIVES US YOUR CONSENT TO USE THIS INFORMATION IN APPROPRIATE SITUATIONS. PLEASE REVIEW IT CAREFULLY.

### **Understanding Your Health Record/Information**

Each time you visit our office, or any other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third party payer can verify that services billed were actually provided

In some circumstances it may also serve as

- a tool in educating health professionals;
- a source of data for medical research;
- a source of information for public health officials charged with improving the health of the nation;
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used may help you to:

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others.

### **Your Health Information Rights:**

Although your health record is the physical property of Dupont Circle Physicians Group, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by Federal Law 45 CFR 164.522
- obtain a paper copy of this notice of information practices upon request
- inspect and copy your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.

### **Our Responsibilities:**

This organization is required to:

- maintain the privacy of your health information
- provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change in a way that affects you, you will be notified of such.

We will not use or disclose your health information without your authorization, except as described in this notice.

### **For More Information or to Report a Problem**

If have questions and would like additional information, you may contact Ben Stearn, Privacy Officer, at (202) 745-0201.

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

### **Examples of Disclosures for Treatment, Payment and Health Operations**

*We will use your health information within our office for treatment. For example:* Information obtained by a physician or other member of your healthcare team will be recorded in your record and used to determine the course of your treatment. Your physician will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way the physician will know how you are responding to treatment.

*We will use your health information for payment. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.*

*We will use your health information for quality control within our office. For example: Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.*

**Other Uses or Disclosures**

*Business Associates:* Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. For example, it may be necessary to obtain specialized assistance to process certain laboratory tests or radiology images. To protect your health information, we require these Business Associates to follow the same standards held by this office.

*Notification:* We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. Please notify us of any restrictions you may want to place on this notification.

*Communication with Family:* Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. Please notify us of any restrictions you may want to place on this notification

*Research:* If you are involved in a research protocol we may disclose, with your consent, information to researchers (only if their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information).

*Food and Drug Administration (FDA):* We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

*Public Health:* As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

*Law Enforcement:* We disclose health information for law enforcement purposes only as required by law, or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a knowledgeable source or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

This notice will be maintained and available for downloading at the following web site address: dupontdocs.com

**Insurance and Payment Authorization**

I authorize Dupont Circle Physicians Group to apply for benefits on my behalf for covered services rendered. I request that payment from my insurer be made directly to Dupont Circle Physicians Group as allowed by my insurance policy.

I certify that the information I have provided with regard to my insurance is correct.

I authorize the release of any information, including medical information for this or any related claim, to my insurance company for the purpose of obtaining payment. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

I agree to pay and accept responsibility for all charges not covered or payable by my insurance as allowed by contractual agreements between Dupont Circle Physicians Group and my insurance company. Unless other agreements have been made, unpaid balances are due within 30 days of billing.

*My signature below indicates that I have read and agree to the provisions of this authorization and been provided with a copy of the notice of privacy policy.*

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

If signed by legal representative, relationship to patient \_\_\_\_\_

Effective Date: 4/14/2003