Pioneer Therapy Center

Notice of Medical Rights & Privacy Practices

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes medical and billing records.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Pioneer Therapy Center. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. $20.00 administration fee/+.91 first 30 pages/ .69 every page thereafter. You will receive your copy within 15 days of receipt of your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that the medical 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 by the practice.

To request an amendment, your request must be made in writing and submitted to Pioneer Therapy Center. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition we may deny your request if you ask us to amend information that:

1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
2. Is not part of the medical information kept by this practice.
3. Is not part of the information, which you would be permitted to inspect and copy.
4. Is accurate and complete.

Any amendment we made to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list or accounting of disclosures, you must submit your request in writing to Pioneer Therapy Center. Your request must state a time period, which may not be longer than 7 years and may not include dates before April 14, 2003. Your request should indicate in which form you want to list (for example, paper or electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a treatment you or your spouse.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to Pioneer Therapy Center. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at the certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Pioneer Therapy Center. We will accommodate all reasonable request. Your request must specify how or where you will be contracted.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy, contact Karen Witters, OT/R.

Changes To This Notice: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of current notice in our facility. The notice will contain the effective date on the first page, second line from the top.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with practice or with the secretary of the Department of Health and Human Services. To file a complaint with the practice contact Karen Witters OT/R 253.377.6285. All complaints must be submitted in writing. *You will not be penalized for filing a complaint.*

Other Uses of Medical Information: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide you.

I acknowledge receipt of a copy of this notice.

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Patient or Person Representative Signature Date