Troy W. Bishop, M.D. LLC
9417 Broadview Road
Broadview Heights, OH 44147
Phone: (440)545-2272
Fax: (440)545-5645

NOTICE OF PRIVACY PRACTICES

Effective July 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ THIS NOTICE CAREFULLY.

At Troy W. Bishop, MD, LLC, we believe that your health information is personal. We keep records of the care and services that you receive at our facilities. We are committed to keeping your health information private, and we are required by law to respect your confidentiality. This Notice describes the privacy practices of Troy W. Bishop, MD, LLC. This Notice applies to all of the health records that identify you and the care you receive at Troy W. Bishop, MD, LLC. If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you. We are legally required to give you this Notice and to follow the terms of the Notice that is currently in effect.

HOW TROY W. BISHOP MD LLC MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

When you become a patient of Troy W. Bishop, MD, LLC we will use your health information within Troy W. Bishop, MD, LLC and disclose your health information outside Troy W. Bishop, MD, LLC for the reasons described in this Notice. The following categories describe some of the ways that we will use and disclose your health information.

Treatment. We use your health information to provide you with health care services. We may disclose your health information to doctors, nurses, technicians, medical or nursing students, or other persons at Troy W. Bishop, MD, LLC who need that information to take care of you. For example, a doctor treating you for a broken leg may need to ask another doctor if you have diabetes because diabetes may slow the leg's healing process. This may involve talking to doctors and others not employed by us. We also may disclose your health information to people outside Troy W. Bishop, MD, LLC who may be involved in your health care, such as treating doctors, home care providers, pharmacies, drug or medical device experts, and family members.

Payment. We may use and disclose your health information so that the health care you receive may be billed and paid for by you, your insurance company, or another third party. For example, we may give information about treatment you had here to your health plan so it will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive so we can get prior payment approval or learn if your plan will pay for the
treatment.

Health Care Operations. We may use your health information and disclose it outside Troy W. Bishop, MD, LLC for our health care operations. These uses and disclosures help us operate Troy W. Bishop, MD, LLC to maintain and improve patient care. For example, we may use your health information to review the care you received and to evaluate the performance of our staff in caring for you. We also may combine health information about many patients to identify new services to offer, what services are not needed, and whether certain therapies are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other persons at Troy W. Bishop, MD, LLC for learning and quality improvement purposes. We may remove information that identifies you so people outside Troy W. Bishop, MD, LLC may study your health data without knowing who you are.

Contacting You. We may use and disclose health information to reach you about appointments and other matters. We may contact you by mail, telephone, text or email. We may leave voice messages at the telephone number you provide us with, and we may respond to your email address.

Health-Related Services. We may use and disclose health information about you to send you mailings about health-related products and services available at Troy W. Bishop, MD, LLC.

Medical Data Exchange. We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment or other healthcare operations. A patient may opt out of sharing his or her information in Exchange by completing an Exchange opt-out form. Please contact office administration to complete form.

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Legal Matters. We will disclose health information about you outside Troy W. Bishop, MD, LLC when required to do so by federal, state, or local law, or by the court process. We may disclose health information about you for public health reasons, like reporting births, deaths, child abuse or neglect, reactions to medications or problems with medical products. We may release health information to help control the spread of disease or to notify a person whose health or safety may be threatened. We may disclose health information to a health oversight agency for activities authorized by law, such as for audits, investigations, inspections, and licensure.

AUTHORIZATIONS FOR OTHER USES AND DISCLOSURES

As described above, we will use your health information and disclose it outside Troy W. Bishop, MD, LLC for treatment, payment, health care operations, and when permitted or required by law. We will not use or disclose your health information for *other* reasons without your written authorization. For example, you may want us to release medical information to your employer or to your child's school. These kinds of uses and disclosures of your health information will be made only with your written authorization. You may revoke the authorization, in writing, at any time, but we cannot take back any uses or disclosures of your health information already made with your authorization.

YOUR RIGHTS REGARDING HEALTH INFORMATION

Right to Accounting. You may request an accounting, which is a listing of the entities or persons (other than yourself) to whom Troy W. Bishop, MD, LLC has disclosed your health information without your written authorization. The accounting would not include disclosures for treatment, payment, health care operations, and certain other disclosures exempted by law. Your request for an accounting of disclosures must be in writing, signed, and dated. It must identify the time period of the disclosures. We will not list disclosures made before July 1, 2013, or those made earlier than 6 years before your request. Your request should indicate the form in which you want the list (for example, on paper or electronically). You must submit your written request to the medical records department of Troy W. Bishop, MD, LLC. We will respond to you within 60 days. We will charge you a reasonable cost-based fee to complete your request.

Right to Amend. If you feel that health information we have about you is incorrect or incomplete, you have the right to ask us to amend your medical records. Your request for an amendment must be in writing, signed, and dated. It must specify the records you wish to amend, and give the reason for your request. We may deny your request; if we do, we will tell you why and explain your options.

Right to Inspect and Obtain Copy. You have the right to inspect and obtain a copy of your completed health records unless your doctor believes that disclosure of that information to you could harm you. You may not see or get a copy of information gathered for a legal proceeding. Your request to inspect or obtain a copy of the records must be submitted in writing, signed and dated, to the medical records department. (Requests for billing records should be sent to the billing departments.) We may charge a fee for processing your request. If Troy W. Bishop, MD, LLC denies your request to inspect or obtain a copy of the records, you may appeal the denial within Troy W. Bishop, MD, LLC.

Right to Request Restrictions. You have the right to ask us to restrict the uses or disclosures we make of your health information for treatment, payment, or health care operations, but we do not have to agree. You also may ask us to limit the health information that we use or disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Again, we do not have to agree. A request for a restriction must be signed and dated. The request should also describe the information you want restricted, say whether you want to limit the *use* or the *disclosure* of the information *or both*, and tell us who should not receive the restricted information. You must submit your request in writing to the medical records department of Troy W. Bishop, MD, LLC. We will tell you if we agree with your request or not. If we do agree, we Will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your health in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Your request for confidential communications must be in writing, signed, and dated. It must specify how or where you wish to be contacted. You need not tell us the reason for your request, and we will not ask. You must send your written request to the medical records department of Troy W. Bishop, MD, LLC. We will accommodate all reasonable requests.

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Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a 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. You may obtain a paper copy of this Notice at Troy W. Bishop, MD, LLC.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Troy W. Bishop, MD, LLC or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Troy W. Bishop, MD, LLC, you must submit your complaint in writing. You will not be penalized for filing a complaint.

CHANGES TO THIS NOTICE

Troy W. Bishop, MD, LLC may change this Notice at any time. Any change in the Notice could apply to medical information we already have about you, as well as any information we receive in the future.

If you have questions about this Notice, you may contact Dr. Troy W. Bishop at (440) 545-2272, 9417 Broadview Road, Broadview Heights, Ohio 44147.

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Acknowledgement of Receipt of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996(HIPAA). I understand that this information can and will be used to:

-Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly

-Obtain payment from third-party payers for my health care services

-Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my provider's *Notice of Privacy Practices* containing more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my health care provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations and I understand that you are not required to agree to requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____ Date:_____

Signature:_____

Relationship to Patient:_____

_ _

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other

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MEDICAL INFORMATION RELEASE AUTHORIZATION

I, _____ born on_____
Hereby give my consent to Troy W. Bishop M.D. LLC to provide such diagnostic and medical treatment as deemed necessary.

I authorize Troy W. Bishop M.D. LLC to release any information that may be necessary to comply with subpoenas, governmental regulations and laws. I also authorize this physician to release the following parties any information they request from the physician: 1) Any insurance company that may be obligated to pay my physician bills; 2) Medicare or Medicaid, if applicable; 3) Any other party who may be obligated to pay my physician bill, for example an employer or HMO; 4) Any agent, independent contractor, intermediary or other party who is obtaining information at the request of or for the benefit of any of the foregoing parties.

For physician services provided to me, I assign to the physician all insurance or other payment made by others for my physician services. This simply means that any insurance company or other party obligated to pay my physician bill may pay the physician directly.

I understand that I am responsible for payment of all bills for any services provided by Troy W. Bishop M.D. If I do not provide the name of an insurance company or other party obligated to pay my bills, I will provide the physician with personal credit information and cooperate with the physician in establishing a plan for payment of my physician services.

_____ _____
Patient or Responsible Party Signature Date

PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS AND MARK THE APPROPRIATE BOX WITH A CHECK MARK THEN SIGN AND DATE BELOW

☐ **NO –** I do not wish my medical information to be released to any person other than myself.

☐ **YES** --- I request and authorize Troy W. Bishop M.D. to review and release my medical information with the following individual.

Name_____ Relationship_____

_____ _____
Patient or Responsible Party Signature Date

Information Annually updated as indicated by my initials:

_____2022 _____2023 _____2024 _____2025