HIPAA NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

Custom Family Care.

Ivan Pivovarov, MD

279 Hughes Road, Madison, Al. 35758

(256) 325-0480

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.

This Notice of Privacy Practice describes how we may use and 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. It also describes your rights to access and control your protected health information. We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of 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 the physician's practice, and any other use by law. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Treatment*:* We will use and disclose your protected health information to provide coordinate, or manage your health care and any related services. This includes the coordination or management of your health care 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, (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include:(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health related benefits and services that may be of interest to you.

As Required By Law:

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, worker's compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when requested by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the HIPAA requirements.

All Other Situations, With Your Specific Authorization:

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. 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 healthcare 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. While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. For example, you may ask us to send information to you at your work address instead of your home address. You do not have to explain the reason for your request. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations.

Right To Inspect and Copy Your Personal Health Information (fees may apply)

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, except for (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS").

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

You have the right to receive an accounting of all disclosures of your personal health information except for disclosures: pursuant to an authorization, for purposes of treatment, payment, health care operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing to our office, Custom Family Care at 279 Hughes Road, Madison, Alabama 35758, (256) 325-0480. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time and will notify you of such changes on the following appointment. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to Custom Family Care, 279 Hughes Road, Madison, Alabama 35758. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our office Custom Family Care at the address, or telephone number listed above.

ACKNOWLEDGE FORM FOR
HIPAA NOTICE OF PRIVACY PRACTICES

Custom Family Care.
Ivan Pivovarov, MD
279 Hughes Road, Madison, Al. 35758
(256) 325-0480

By signing below, I hereby acknowledge receipt of the privacy notice for Custom Family Care.

_____ _____
Printed Name of Patient Date

_____
Signature of Patient or Patient's Representative

_____
Printed Name of Patient's Representative (if applicable)

_____
Representative's Relationship to Patient (if applicable)

To be completed by Custom Family Care.

After a good faith attempt to obtain an Acknowledgement of receipt, the patient or representative Refused or was unable to sign the Privacy Notice for the following reason(s) _____
_____
_____
_____

_____ _____
Signature of Custom Family Care Representative Date

Custom Family Care
Ivan Pivovarov, MD
279 Hughes Road, Madison, AL 35758
(256) 325-0480

Consent For Treatment and Release of Information

The following information is to be completed by the patient or the patient's legally authorized representative/parent:

I consent to medical treatment for myself or for the patient for whom I am parent or legally authorized representative. I understand that Custom Family Care will share patient information according to federal and state law for treatment, payment, and operations.

I consent to release my health information to:

Name:_____ Phone:_____ Relationship:_____

I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. The patient agrees to pay for services as the patient incurs the charges. I authorize the insurance provider to pay Custom Family Care for services rendered.

Signature of Patient: _____ Date: _____

Signature of Legally Authorized Representative: _____

Relationship of Legally Authorized Representative to Patient: _____

Date: _____

PATIENT DEMOGRAPHIC FORM

Patient First Name:_____ Last Name:_____

Date of Birth:_____ SSN:_____ Gender:_____

Home Address: Street_____

City_____ State_____ Zip Code_____

Phone: home (_____) ____ -_____ cell (____) ____ -_____ work (____) ____ -_____

Marital Status: married___ single___ divorced___ separated___ widowed___

Language (other than English):_____ Race_____ Ethnicity_____

Reason for visit:_____ Preferred Pharmacy with Address: _____

How did you hear about us:_____ Email _____

PRIMARY INSURANCE

Ins Co Name_____ Policy/Member ID#_____ Group ID#_____

Patient relation to insured: self____ spouse____ child___ other_____

Policy Holder:_____ Gender_____

Home Address: Street_____

City_____ State_____ Zip Code_____

Phone: home (____) ____-_____ cell (____) ____-_____ work (____) ____-_____

Date of Birth:_____ Employer_____

SECONDARY INSURANCE

Ins Co Name_____ Policy/Member ID#_____ Group ID#_____

Patient relation to insured: self____ spouse____ child___ other_____

Policy Holder:_____ Gender_____

Home Address: Street_____

City_____ State_____ Zip Code_____

Phone: home (____) ____-_____ cell (____) ____-_____ work (____) ____-_____

Date of Birth:_____ Employer_____