



Professional Therapy Services, Inc.

*"for those who expect more..."*

## Notice of Privacy Practices

Effective April 14, 2003

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.

### WHO WE ARE

This notice describes the privacy practices of Professional Therapy Services, Inc., and its employees ("PTS," "we" or "us"). It also applies to all business associates with whom we may share information. It applies to your medical information, including your medical record, for all services provided to you in our clinically integrated care setting at any of our outpatient clinics or contracted sites.

We understand that your medical information is confidential and we are committed to maintaining its privacy. Federal law requires that we provide you with this Notice of our legal duties and privacy practices with respect to your medical information. We are required to abide by the terms of this Notice when we use or disclose your medical information.

### HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

We may use and disclose medical information about you without your prior authorization for the following reasons:

**Treatment Purposes** We may disclose your medical information to other providers involved in your treatment or to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health related health benefits and services that may be of interest to you.

**Payment Purposes** Such as sending billing information to Medicare, Medicaid, your health insurer, HMO, or other company or program that will pay for your health care.

**Health Care Operations** We may use your medical information to evaluate the quality and competence of our therapists and assistants. We may disclose medical information to our Compliance Officer in order to resolve any complaints you may have and ensure that you have a comfortable visit with us.

We may also disclose medical information to other health care providers when such medical information is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities and reviewing the quality and competence of health care professionals.

### **Disclosure to Family, Close Friends and Other Caregivers**

We may disclose medical information about you to a family member, other relative, or a close personal friend who is involved in your medical care or to disaster relief authorities so that your family can be notified of your location and condition.

If you are not present, or you are incapacitated or in an emergency situation, we may exercise our professional judgment to decide whether a disclosure is in your best interest. Under these circumstances, we would only disclose information that we believe is directly relevant to the person's involvement with your health care.

**Other Disclosures** We may also use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you for: **Public Health Activities** for the purpose of preventing or controlling diseases; **abuse and neglect**, to government authority if we reasonably believe you are a victim of abuse, neglect or domestic violence; **health oversight activities or inspections**, to a health oversight agency that oversees the health care system; **judicial, administrative and law enforcement purposes**, for example, in response to a subpoena or a request by a law enforcement officer; and we may also disclose your medical information for **research studies, workers' compensation purposes, your health and safety**, and when it is required by law.

### **USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION**

For any purpose other than the ones described above, we will only use or disclose your medical information when you give us your written authorization. For instance, we will obtain your written authorization before sending your medical information to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

**Marketing** We will obtain your written authorization prior to using your medical information to send you any marketing materials. We can provide you with marketing material in a face-to-face encounter without obtaining your authorization. We are also allowed to give you a promotional gift of nominal value, if we choose, without obtaining your authorization. In addition, we may communicate with you about products or services related to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care setting without your authorization.

**Highly Confidential Information** Federal and Illinois law requires special privacy protections for Highly Confidential Information about you. Highly Confidential Information consists of medical information related to: Medical History and conditions; diagnosis of treatment; child abuse and neglect; domestic abuse of an adult with a disability; or sexual assault. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

## **YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION**

**For Further Information; Complaints** If you have questions or are concerned that your privacy rights have been violated or you disagree with a decision that we made about access to your medical information, you may contact our Compliance Officer. You may also file written complaints with the Director, Office for Civil Rights of the US Department of Health and Human Services. Our Compliance Officer will provide you with the address. We will not retaliate against you if you file a complaint.

**Right to Request Additional Restrictions** You may request, in writing, that we not use or disclose medical information about you for treatment, payment or health care operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider all requests for additional restrictions carefully; however, we are not required to accept them. If you wish to request additional restrictions, please obtain a request form from our Billing Office and submit the completed form to the Billing Office. We will send you a written response.

**Right to Receive Confidential Communications** You may request, and we will accommodate, any reasonable written request for you to receive your medical information by alternative means of communication or at alternative locations, such as sending mail to an address other than your home.

**Right to Revoke Your Authorization** You have the right to revoke your written authorization obtained in connection with the release of your medical information, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to our Privacy Office. A written revocation form is available upon request from the Billing Department.

**Right to Inspect and Copy Your Health Information** You have the right to look at or get a copy of your medical record file and billing records maintained by us. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from the PTS Billing Officer or your physician's office and submit the completed form to the Billing Office or your physician's office. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies.

**Right to Amend Your Records** You have the right to request that we amend your medical record file or billing records by obtaining an amendment request form from the Billing Department and submitting the completed form to the Billing Department. We will comply with your request unless we believe that the information is accurate or other special circumstances apply. You have the right to appeal our decision not to amend your medical records.

**Right to Receive an Accounting** You may obtain an accounting of certain disclosures of your medical information made by us in the six (6) years prior to your request; however, it does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you \$0.50 per page of the accounting statement.

**Right to Receive Paper Copy of this Notice** Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such Notice electronically.

**Right to Change Terms of this Notice** We may change this Notice at any time. If we change this Notice, we may make the new Notice terms effective for all medical information that we maintain, including any information created or received prior to issuing the new Notice. If we change this Notice, we will post the new Notice in waiting areas around our offices. You also may obtain any new Notice by contacting the Billing Office.

*The effective date of this notice is April 14, 2003.*

### **Privacy Office**

You may also contact the Privacy Office at:

Professional Therapy Services, Inc. –Compliance  
112 NE Madison Ave.  
Peoria, IL 61602  
Telephone: (309) 674-7874  
E-Mail: [cindyr@ptsinc.org](mailto:cindyr@ptsinc.org)

### **Billing Office**

Professional Therapy Services, Inc.  
2810 Frank Scott Parkway West – Suite 824  
Belleville, IL 62223  
Telephone: (618) 234-9705  
E-Mail: [billing@ptsinc.org](mailto:billing@ptsinc.org)

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By signing below, I hereby acknowledge receipt of the Professional Therapy Services, Inc. Notice of Privacy Practices and consent to the uses and disclosures described in the Notice of Privacy Practices.

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Signature of Patient (*Legal or Personal Representative*)

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Date of Signature

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

Revised 11/2010