

RODNEY Z. WONG, M.D.

Orthopedic Surgery & Sports Medicine

NOTICE OF PRIVACY PRACTICES

Treatment,

We will use your health information within our office to provide you with the best health care possible. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

Public Health and National Security,

It is also possible that health information will be disclosed during audit by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. We may also be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payments. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Abuse or Neglect,

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

To Obtain Payment,

We may include your health information with an invoice used to collect payment for treatment you received in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with similar commitment to the security of your health information.

Policy For Canceling or Missing an Office Visit,

We are a very busy practice. We often have a waiting list for appointments that patients need. Please give us as much notice, if you need to cancel a visit – so we can get another patient cared for. All missed appointment fees are not covered by insurance plans. It may be your responsibility to pay before or at your next visit. If you need to cancel or reschedule an appointment, please call us at least 24 hours ahead. If you fail to arrive for your appointment and have not notified us 24 hours in advance, you may be charged. Staffing, materials, and our time are required to prepare for your appointment – and those expenses remain. The “No Show Fee” is \$30.00. If you have missed three appointments, please discuss your schedule with our office staff. You may benefit from seeing us at a different time and/or day or seeing someone closer to you.

Policy For Filling out Forms,

Please allow at least 5 business days for all forms to be completed. We will strive to do this in a shorter time frame but that is not always possible. We would be happy to arrange for pick up. There is a nominal \$10.00 charge to fill out a 1 page disability form and \$5.00 for any additional pages. For disability papers involving surgery, forms will be filled out after the procedure. Surgery procedure codes are required and these are not always known until the operation is completed. Any other forms, please contact our office for fees. Fees are calculated depending on the time that it takes the doctor to fill them out.

Continue on back

Patient's Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

You have the right to request that we communicate with you in certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor you reasonable requests for confidential communications.

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know 5 working days in advance. We will need to charge you a reasonable fee to duplicate and assemble your copy.

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not a part of our records or if the records containing your health information are determined to be accurate and complete.

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more that three years at a time. We may need to charge you a reasonable fee for your request.

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients received a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Patient acknowledgment;

Thank you very much for taking the time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much you acknowledging your receipt of our policy by signing and returning this form. We look forward to seeing you again soon!

Patient's name. Please print

Patient or responsible party's signature

Date