**HEALTHY LYMPHATICS OF NC, PC**

**Phone: 828-355-9584**

**Fax: 828-355-9689**

**Healthy Lymphatics-Boone office Healthy Lymphatics-Elkin office Healthy Lymphatics-Mt. Airy office**

**450 New Market Blvd Ste 3 2015 North Bridge St 905 Rockford St**

**Boone, NC 28607 Elkin, NC 28621 Mount Airy, NC 27030**

**Healthy Lymphatics-North Wilkesboro office Healthy Lymphatics-Galax VA office**

**1912 West Park Drive 812 West Stuart Drive**

**North Wilkesboro, NC 28659 Galax, VA 24333**

**NOTICE OF PRIVACY PRACTICES**

**Protected health information about you is maintained as a record of your contacts or visits for physical**

**therapy services with our practice(s). Specifically, “protected health information” is information about**

**you, including demographic information (i.e., name, address, phone, etc.) that may identify you and**

**relates to your past, present or future physical health condition and related health care services.**

**Our practice is required by law to follow specific rules on maintaining the confidentially of your**

**protected health information, using your information and disclosing or sharing this information with**

**other healthcare professionals involved in your care and treatment. This notice describes your rights**

**to access and control your protected health information. It also describes how we follow applicable**

**rules and use and disclose your protected health information to provide your treatment, obtain payment**

**for services you receive, manage our health care operations and for the other purposes that are**

**permitted or required by law.**

**We are required to abide by the terms in the notice. We reserve the right to change the terms of this**

**notice at any time and those changes will go into effect at that time. Upon request we will provide you**

**with a copy of the revised notice.**

**YOUR RIGHTS UNDER THE PRIVACY RULE**

**You have the right to receive a copy of this notice. You have the right to authorize other use and**

**disclosure. You may authorize or deny any use or disclosure and you may revoke your authorization**

**at any time, in writing.**

**You have the right to designate a personal representative who will have the authority to authorize the**

**use or disclose your protected health information. You have the right to inspect and copy your protected**

**health information. We have the right to charge a reasonable fee for copies as established**

**professional, state or federal guidelines.**

**You have the right to request a restriction of your protected health information by asking us in writing**

**not to use or disclose any part of your protected health information for the purposes of treatment,**

**payment or healthcare operations. In certain cases, we may deny your request for a restriction. You also**

**have the right to request disclosure accountability by requesting a listing of disclosures that we have**

**made to entities or persons outside of our office.**

**HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

**We may use and disclose your information to provide, coordinate or manage your physical therapy**

**treatment. Specifically, this would involve your referring physician, workers compensation case**

**manager and/or adjuster. We will also disclose your information to obtain coverage and benefits**

**as well as payment from your insurance carrier.**

**COMPLAINTS**

**You may complain to us or the Centers of Health and Human Services if you believe your privacy rights**

**have been violated by us. You may file a complaint with us by notifying us in writing. Our mailing**

**address is HEALTHY LYMPHATICS OF NC, PC-450 NEW MARKET BLVD., SUITE 3, BOONE, NC 28607.**

**PATIENT HEALTH INFORMATION RELEASE**

**I have read and fully understand HEALTHY LYMPHATICS OF NC, PC’s Notice of Information Practices. I**

**understand that HEALTHY LYMPHATICS OF NC, PC may use or disclose my personal health information**

**for the purposes of carrying out treatment, obtaining payment from insurance companies, evaluating**

**the quality of services provided and any other administrative operations related to treatment or**

**payment. I understand that I have the right to restrict how my personal health information is used and**

**disclosed for treatment, payment and administrative operations if I notify the facility in writing. I also**

**understand that HEALTHY LYMPHATICS OF NC, PC will consider requests or restrictions on a case-by-case**

**basis, but does not have to agree to requests for restrictions.**

**I hereby consent to the use and disclosure of my personal health information for purposes as noted in**

**HEALTHY LYMPHATICS OF NC, PC’s Notice of Information Practices. I understand that I retain the right**

**to revoke this consent by notifying the company in writing at any time.**

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**PATIENT PRINT NAME**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT SIGNATURE**

**\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE**