



UniPlus Health LLC

NOTICE OF PRIVACY PRACTICES

Effective 10/16/2020

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 Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use or disclose your protected health information and with whom we may share that information. "Protected health information" is individually identifiable health information. Such information may include, for example, your age, address, or e-mail address, and it relates to your past, present, and future physical or mental health or condition and related health care services. It is information that you have given to us or that we have learned about you when you were a patient. This Notice also describes your rights and our legal duties related to this information.

I. Acknowledgement of Receipt of this Notice. You will be asked to provide a signed acknowledgement of your receipt of this Notice to ensure that you are aware of the possible uses and disclosures of your protected health information and privacy rights. Delivery of your health care services is not conditioned upon your signature. If you decline to provide a signed acknowledgement, we will continue to provide treatment to you and will use and disclose your protected health information for treatment, payment, and health care operations as necessary.

II. Uses and Disclosures of Protected Health Information for Treatment, Payment, and Health Care Operations.

- A. *Treatment, Payment, and Health Care Operations.* The following describes different ways we use and disclose your protected health information for treatment, payment, and health operations, including examples of each.
 - i. Treatment. We may use or disclose your health information to provide you with medical and behavioral health services, including substance abuse prevention, treatment, and intervention. You must sign a written consent before we can share your information for treatment purposes. If you consent, we may disclose your information to people providing, managing, and coordinating your care. This includes the coordination or management of your care with a third party. For example, we may disclose your protected health information to a counselor or case manager so he or she can make decisions related to your care. We may also disclose information to a pharmacist about other drugs you have been prescribed to avoid potential adverse interactions.
 - ii. Payment. We may use or disclose your health information so that we can bill and collect payment from you, an insurance company, or someone else for the health care services you receive from us. We may also tell your health plan about a treatment you are going



to receive to obtain prior approval or to determine whether the plan will pay for the treatment. For example, we may need to give your health plan information about a planned drug screening so your health plan will pay us or reimburse us for the screening.

- iii. Health Care Operations. We may use or disclose your health information, if you sign a written consent, to run necessary administrative, business management, quality assurance, internal audit, and educational functions. For example, we may use or disclose your health information to conduct competence and qualification evaluations of our staff that care for you. We may use health information to help us decide what additional services we should offer, how we can improve efficiency, or whether certain treatments are effective.
 - iv. Fundraising Activities. As part of our health care operations, we may use and disclose a limited amount of your health information to contact you for fundraising efforts. The health information released for these fundraising purposes can include your name, address, other contact information, gender, age, date of birth, dates on which you received service, health insurance status, the outcome of your treatment with us and your treating physician's name. Any fundraising communications you receive from us will include information on how you can elect not to receive any further fundraising communications. You can tell us not to contact you again.
- B. *Other Uses and Disclosures of Health Information Without Authorization*. In addition to uses and disclosures of your health information for treatment, payment, and health care operations, we may also use or disclose health information without authorization in the following circumstances:
- i. To you, the patient.
 - ii. If ordered by a court.
 - iii. For health oversight activities such as, for example, internal and external investigations, inspections, or licensure actions.

III. Uses and Disclosures of Protected Health Information Only With Authorization.

- A. Except for the purposes defined and listed above, we will not use or disclose your health information for any purpose unless you give us your written authorization. Circumstances that may require written authorization include use or disclosure of psychotherapy notes, for marketing purposes, and for the sale of your health information.
- B. *Revocation of Authorization*. If you give us an authorization, you can withdraw or amend this written authorization at any time. To withdraw your authorization, deliver a written revocation 35 Bill Fries Dr Building J, Hilton Head Island, South Carolina 29926 or Fax: 843-990-4037. If you revoke your authorization, we will no longer use or disclose your health information as allowed by your written authorization, except to the extent that we have already relied on your authorization.

IV. Your Rights Regarding Your Protected Health Information.



- A. You have certain rights regarding your health information, which are listed below. If you want to exercise any of your rights, you must do so in writing by completing a form that you can obtain from our Privacy Officer. In some cases, we may charge you for the costs of providing materials to you. You can get more information about how to exercise your rights and about any costs that we may charge for materials by contacting our Privacy Officer at 843-990-4008.
- i. *Right to Inspect and Copy.* With some exceptions, you have the right to inspect and get a copy of the health information that we use to make decisions about your care. For the portion of your health record maintained in an electronic health record, if any, you may request that we provide that information to or for you in an electronic format. If you make such a request, we are required to provide that information for you electronically (unless we deny your request for other reasons). We may deny your request to inspect and/or copy in certain limited circumstances, and if we do this, you may ask that the denial be reviewed.
 - ii. *Right to Amend.* You have the right to amend your health information maintained by or for us, or used by us to make decisions about you. We will require that you provide a reason for the request, and we may deny your request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create (unless the source of the information is no longer available to make the amendment); (b) is not part of the health information that we keep; (c) is of a type that you would not be permitted to inspect and copy; or (d) is already accurate and complete.
 - iii. *Right to an Accounting of Disclosures.* You have the right to request a list and description of certain disclosures by us of your health information.
 - iv. *Right to Request Restrictions.* You have the right to request a restriction or limitation on the protected health information we use or disclose about you (a) for treatment, payment, or health care operations, (b) to someone who is involved in your care or the payment for it, such as a family member or friend, or (c) to a health plan for payment or health care operations purposes when the item or service has been paid for out of pocket in full by you or someone on your behalf (other than the health plan). For example, you could ask that we not use or disclose information about a laboratory test ordered or a medical device prescribed for your care. Except for the request noted in (c) above, we are not required to agree to your request. Any time we agree to such a restriction, it must be in writing and signed by our Privacy Officer or his or her designee.
 - v. *Right to Request Confidential Communications.* You have the right to request that we communicate with you about health matters in a certain way or at a certain place. We will accommodate reasonable requests. For example, you can ask that we only contact you at work or by mail.
 - vi. *Right to a Paper Copy of This Notice.* You have the right to a paper copy of this Notice, whether or not you may have previously agreed to receive the Notice electronically.
 - vii. *Right to be Notified of a Breach.* You have the right to be notified if there is a breach (a



compromise to the security or privacy of your health information) due to your health information being unsecured. We are required to notify you within 60 days of discovery of a breach.

V. Revisions to this Notice. We have the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you, as well as any information we receive in the future. Except when required by law, a material change to any term of the Notice may not be implemented prior to the effective date of the Notice in which the material change is reflected. We will post the revised Notice at clinical locations and on our website and provide you a copy of the revised notice upon your request.

VI. Questions or Comments. If you have any questions about this Notice, please contact our Privacy Officer at 843-990-4008. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at 843-990-4008. You will not be penalized for filing a complaint. This Notice tells you how we may use and share health information about you. If you would like a copy of this Notice, please ask your health care provider.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices from UniPlus Health LLC. I am aware of the possible uses and disclosures of my protected health information and privacy rights.

Name: _____

Signature: _____

Name: _____

Date: _____