

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

When the Notice refers to “we” or “us,” it is referring to, Joseph E. Chebli, MD, FACS all of the Physicians in the Practice, and all of our employees.

This Notice describes how we will use and disclose your protected health information. The policies outlined in this Notice apply to all of your health information generated by us, whether recorded in your medical record, invoices, payment forms, videotapes or other ways. Similarly, these policies apply to the protected health information gathered from other organizations by any health care professional, employee or volunteer who participates in your care.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

1. In some circumstances we are permitted or required to use or disclose your protected health information without obtaining your prior authorization and without offering you the opportunity to object. These circumstances include;
 - a. Uses or disclosures for purposes relating to treatment, payment and health care operations:

1. **TREATMENT**. We may use or disclose your protected health information for the purpose of providing, or allowing others to provide, treatment to you or any other individual. An example would be if your physician discloses your health information to another doctor for the purposes of a consultation. Also, we may contact you with appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- ii. **PAYMENT**. We may use and/or disclose your protected health information for the purpose of allowing us, as well as other entities, to secure payment for the health care services provided to you. For example, we may inform your health insurance company of your diagnosis and treatment in order to assist the inquirer in processing our claim for payment for health care services provided to you.

- iii. **HEALTH CARE OPERATIONS**. We may use and/or disclose your information for the purposes of our day-to-day operations and functions. We may also disclose your information to another covered entity to allow it to perform its day-to-day functions to the extent that we both have a relationship with you or if we are part of an “organized health care management” with the other entity, such as the hospitals where

our physicians practice. For example, we may compile your protected health information, along with that of other patients, in order to allow us to review that information and make suggestions concerning how to improve the quality of care.

- b. To create materials(s) that originally had any identifying information concerning you deleted from the final material(s);
 - c. To create materials that have most of the identifying information about you deleted from the final materials, to allow other entities to conduct research, public health, or health care operation activities;
 - d. When required by law;
 - e. For public health purposes;
 - f. To disclose information about victims of abuse, neglect, or domestic violence;
 - g. For health oversight activities, such as audits or civil, administrative or criminal investigations;
 - h. For judicial or administrative proceedings;
 - i. For law enforcement purposes;
 - j. To assist coroners, medical examiners or funeral directors with their official duties;
 - k. To facilitate organ, eye or tissue donation;
 - l. For certain research projects that have been evaluated and approved through a research approval process that takes into account patients' need for privacy;
 - m. To avert a serious threat to health or safety;
 - n. For specialized governmental functions, such as military, national security, criminal corrections, or public benefit purposes; and
 - o. For workers' compensation purposes, as permitted by law.
2. We may also disclose to your relatives or close personal friends any protected health information that is directly related to that person's involvement in the provision of, or payment for your care. We may also use and disclose your protected health information for the purpose of locating and notifying your relatives or close personal friends of your location and general condition or death, and to Organizations that are involved in those tasks during disaster situations. Except in emergency situations, we will inform you that we intend to share information in this way and will give you an opportunity to object.

Except as described above, disclosures of your protected health information will be made only with your written authorization. You may revoke your authorization at any time, in writing, unless we have taken action in reliance upon your prior authorization, or if you signed the authorization as a condition of obtaining insurance coverage.

YOUR RIGHTS

1. **TO REQUEST RESTRICTIONS.** You have the right to request restrictions on the use and disclosure of your protected health information for treatment, payment or health care operations purposes or notification purposes. We are not required to agree to your request. If we do agree to a restriction, we will abide by that restriction unless you are in need of emergency treatment and the restricted information is needed to provide that emergency treatment. To request a restriction, submit a written request to the Contact Person listed on the final page of this Notice.
2. **TO LIMIT COMMUNICATIONS.** You have the right to receive confidential communications about your own protected health information by alternative means or at alternative locations. This means that you may, for example designate that we contact you only via e-mail, or at work rather than home. To request communications via alternative means or at alternative locations, you must submit a written request to the Contact Person listed on the final page of this Notice. All reasonable requests will be granted.
3. **TO ACCESS AND COPY HEALTH INFORMATION.** You have the right to inspect and copy any protected health information about you, that we use to make decisions about you, other than psychotherapy notes, information compiled in anticipation of or for use in civil, criminal or administrative proceedings, or certain information that is governed by the Clinical Laboratory Improvement Act. To arrange for access to your records, or to receive a copy of your records, you should submit a written request to the Contact Person listed on the last page of this Notice. If you request copies, you will be charged our regular fee for copying and mailing the requested information.

Despite your general right to access your Protected Health Information, access may be denied in some limited circumstances. For example, access may be denied if you are an inmate at a correctional institution or if you are a participant in a research program that is still in progress. Access may be denied if the federal Privacy Act applies. Access to information that was obtained from someone other than a health care provider under a promise of confidentiality can be denied if allowing you access would reasonably be likely to reveal the source of the information. The decision to deny access under these circumstances is final and not subject to review.

In addition, access may be denied if, (I) access to the information in question is reasonably likely to endanger the life and physical safety of you or anyone else, (II) the information makes reference to another person and your access would reasonably be likely to cause harm to that person, or (III) you are the personal representative of another individual and a licensed health care professional determines that your access to the information would cause substantial harm to the patient or another individual. If access is denied for these reasons, you have the right to have the decision reviewed by a health

care professional who did not participate in the original decision. If access is ultimately denied, the reasons for that denial will be provided to you in writing.

4. **TO REQUEST AMENDMENT.** You may request that your protected health information be amended. Your request may be denied if the information in question; was not created by us (unless you show that the original source of the information is no longer available to seek amendment from), is not part of our records, is not the type of information that would be available to you for inspection or copying (for example, psychotherapy notes), or is accurate and complete. If your request to amend your protected health information is denied, you may submit a written statement disagreeing with the denial, which we will keep on file and distribute with all future disclosures of the information to which it relates. Requests to amend protected health information must be submitted in writing to the Contact Person listed on the final page of this Notice.

5. **TO AN ACCOUNTING OF DISCLOSURES.** You have the right to an accounting of any disclosures of your protected health information made during the six-year period preceding the date of your request. However, the following disclosures will not be accounted for. (I) disclosures made for the purpose of carrying out treatment, payment or health care operations, (II) disclosures made to you, (III) disclosures of information maintained in our patient directory, or disclosures made to persons involved in your care, or for the purpose of notifying your family or friends about your whereabouts, (IV) disclosures for national security or intelligence purposes, (V) disclosures to correctional institutions or law enforcement officials who had you in custody at the time of disclosure, (VI) disclosures that occurred prior to April 14, 2003, (VII) disclosures made pursuant to an authorization signed by you, (VIII) disclosures that are a part of a limited date set, (IX) disclosures that are incidental to another permissible use or disclosure, or (X) disclosures made to a health oversight agency or law enforcement official, but only if the agency or official asks us not to account to you for such disclosures and only for the limited period of time covered by that request. The accounting will include the date of each disclosure, the name of the entity or person who received the information and that person's address (if known), and a brief description of the information disclosed and the purpose of the disclosure. To request an accounting of disclosure, submit a written request to the Contact Person listed on the final page of this Notice.

6. **TO A PAPER COPY OF THIS NOTICE.** You have the right to obtain a paper copy of this Notice upon request.

OUR DUTIES

1. We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of our legal duties and privacy practices.

2. We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make those changes applicable to all protected health information that we maintain. Any changes to the Notice will be posted at our office, and will be available from us upon request.

COMPLAINTS

You can complain to us and to the Secretary of the federal Department of Health and Human Services if you believe your privacy rights have been violated. To lodge a complaint with us, please file a written complaint with the Contact Person set forth below. This contact person will also provide you with further information about our privacy policies upon request. No action will be taken against you for filing a complaint.

DESIGNATED CONTACT PERSON:

JOSEPH E. CHEBLI, MD, FACS
10330 Meridian Avenue North
Suite 390
Seattle, Washington 98133
206-368-1230

SUMMARY NOTICE OF PRIVACY PRACTICES

We are required by federal law to provide a Notice of Privacy Practices that describes how health information that we maintain about you may be used or disclosed. The Notice describes each use and disclosure that we are permitted to make, and provides a description of your rights and our obligations under federal and state privacy laws.

CONSENT FOR EVALUATION AND TREATMENT

I hereby authorize Joseph E. Chebli, MD and/or his affiliates, their physicians, employees or agent, together with any laboratory designated by Joseph E. Chebli, MD or any of his affiliates to perform a physical examination and/or any medical treatment deemed necessary by the treating physicians. This includes, but is not limited to, any required medical examinations, x-rays, medical procedures and medical, diagnostic or laboratory test ordered by the physician(s) to be carried out by the designated staff.

I voluntarily authorize Joseph E. Chebli, MD and/or his affiliates, their physician, employees or agents, together with any laboratory to obtain a specimen of my urine, blood, and/or breath for the purpose of determining the presence of drugs and/or alcohol, if applicable.

RELEASE OF INFORMATION

I voluntarily authorize Joseph E. Chebli, MD and/or his affiliates to disclose to my employer, prospective employer, insurance company and/or any third party payer all medical information, test results and findings made during the course of this examination and/or treatment. I authorize Joseph E. Chebli, MD to release any appropriate information concerning my medical history, examinations, treatments, or other diagnostic procedures, including copies of my records to official requesters, including but not limited to insurance companies, third party administrators, or utilization, review organizations, health care service plans, or to any other person or entity as necessary in connection with certification, payment or reimbursement for services rendered. I acknowledge that such information may be released pursuant to the following paragraph.

CONFIDENTIALITY

It is the policy of Joseph E. Chebli, MD and his affiliates to protect all medical records against loss, tampering, destruction and access by unauthorized persons. I understand that medical records maybe periodically reviewed by national accreditation or certification surveyors, and other necessary quality assurance personnel and I authorize such release of information. I acknowledge that my records and associated documentation may be disclosed to third-parties, including government agencies, as required by law, including, but not limited to, pursuant to warrant, subpoena or court order, and I hereby agree not to pursue any action against Joseph E., Chebli, MD and/or his affiliates for any damage I may suffer as a result of such disclosure.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign to Joseph E. Chebli, MD and/or his affiliates any and all benefit of payments for services rendered under terms of my insurance policies, and hereby individually obligate the payer to pay the account to Joseph E. Chebli, MD and/or his affiliates in accordance with the standard and customary charges incurred during my period of treatment.

FINANCIAL AGREEMENT

I understand I am responsible for all deductibles, co-pays and charges for services rendered to me but not covered by my insurer. If I am liable for payment, a list of charges will be made available to me within (30 days) from the date Joseph E. Chebli, MD and/or his affiliates become aware of my insurance ineligibility. Should the account be referred to collection, the undersigned shall pay the collection expenses incurred by Joseph E. Chebli, MD and/or his affiliates, including, without limitation, court costs and attorney's fees.

USES AND DISCLOSURES

We are permitted to use and disclose your health information under a variety of circumstances. Sometimes we must obtain your authorization before we use or disclose that information, but in other circumstances we may use your information without your authorization and without informing you of the use or disclosure. Some of the reasons that we may use or disclose your information include:

- . to provide information about your health condition to others who may treat you;
- . to provide information about the treatment that we provided in order to obtain payment from your health plan;
- . to report a communicable disease, domestic violence or criminal activity; or
- . to comply with a court order requiring the disclosure of your medical record.

These are just a few examples. For a full description of the uses and disclosures that we are permitted to make, consult the Notice of Privacy Practices.

YOUR RIGHTS

While the records that we maintain about you belong to us, under the federal privacy law you have a variety of rights with respect to the information maintained in those records. For instance, you have the right to access and copy the health information that we maintain about you and to request that we amend any of the information that you believe is incomplete or incorrect. Also, you may request that we provide you with a list of each disclosure that we have made of your health information. All of these rights are subject to some exceptions that are described fully in the Notice.

OUR OBLIGATION

We are required to provide you with our Notice of Privacy Practices and to abide by its terms. We may amend the Notice from time to time. All amendments apply retroactively.

Our full Notice of Privacy Practices is attached or enclosed. Please read it carefully. If you have any questions or require additional information please contact:

Joseph E. Chebli, MD, FACS
Privacy Officer
206-368-1230

By my signature below I acknowledge that I have fully read Dr. Joseph E. Chebli's Summary Notice of Privacy Practices and fully understand it's contents and have been given a copy of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of patient

Relationship