PRIORITY PSYCHIATRY

95 Vernon Street, Suite 302
Worcester, MA 01610

NOTICE OF PRIVACY PRACTICES

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 WILL FOLLOW THIS NOTICE: This notice describes information followed by me or by any staff or associate. The "designated privacy officer" is Momen El Nesr, M.D

YOUR HEALTH INFORMATION: This notice applies to the information and records I have about your health, health status, and the health care and services you receive at this office.

HOW I MAY USE AND DISCLOSE YOUR HEALTH INFORMATION: I must have your written signed consent to use and disclose health information for the following purposes:

1. For Treatment. I use health information about you to provide medical treatment or services. I may share information about you and disclose information to others in order to coordinate your care, such as phoning/faxing prescriptions to you pharmacy and scheduling/ordering lab work. Family members and other providers may be part of you medical care and may require information about you that I have.

2. For Payment. I may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment collected from you, an insurance company, or a third party. For example, I may need to give your health plan information about services you receive here so that they will pay me or reimburse you for services provided. I may also tell you health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

3. For Health Care Operations. If I hire additional staff, I may use and disclose health information about you to make sure you receive quality care, for example, to help with scheduling or billing.

4. Appointment Reminders. I may contact you as a reminder for your coming appointment

5. Treatment Alternatives. I may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

6. Health-Related Services. I may tell you about health-related services that may be of interest to you. Please notify me if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related services. If you advise me that you do not wish to receive such communications, I will not use or disclose you information for these purposes.

YOU MAY REVOKE YOUR CONSENT at any time by giving me written notice. Your revocation will be effective when I receive it, but it will not apply to any uses and disclosures that occurred before that time. If you revoke your consent, I will not be permitted to use or disclose information for purposes of treatment, payment, or health care operation, and I may therefore choose to discontinue providing you with my services.

I read HIPPA policy

Name : Signature: Date: