POINT Acupuncture | Asian Medicine
2565 Hamline Avenue N., Suite B, Roseville, MN 55113, Phone: 651-699-2002

NOTICE OF PRIVACY POLICIES

Our office is dedicated to providing service with respect and dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. We are required to tell you how we will be keeping your protected health information confidential. We are asking each patient to sign an acknowlegment form that they received this notice.

We gather personal and health information in several ways:
1. We gather information from you
2. Information we receive from other health care providers
3. Information we receive from third party payers

YOUR HEALTH INFORMATION MAY BE USED FOR THE FOLLOWING PURPOSE
You should be aware that during the course of our relationship with you, we will likely use and disclose health information about you for treatment, payment, and healthcare operations.
1. We may use your health information to provide, coordinate and manage health care treatment or services. We may disclose health information about you to health professionals who are involved in taking care of you.
2. We may use information to receive payments from you, an insurance company, or third party for services we provide.
3. We may use information for certain activities related to business functions of this office.
4. We may use and disclose health information to contact you as a reminder that you have an appointment or we may need to reschedule your appointment.
5. Unless you object, we may disclose your information to your family members, relatives, close personal friends or any person you identify who is involved in your health care or payment for such health care.
6. We may use and disclose health information to inform you about or recommend possible aftercare treatment options that may benefit you.
7. We may use or disclose minimally necessary health information about you for research purposes.
8. We may disclose or use minimally necessary health information for other special situations such as for averting a serious threat to health or safety or for workers' compensation purposes.
9. We will disclose minimally necessary health information about you when required to do so by federal, state or local law.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS
You may specifically authorize us to use protected heath information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to share your protected health information.

MARKETING
This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, and newsletters, postcards, letters or calls.

PATIENT RIGHTS
1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have the right to receive all notices in writing.

If you have questions, complaints, or want more information, please contact this office. Complaints about your privacy rights or how your privacy is handled at this office can be directed to the privacy officer by calling this office or directing a letter to his/her attention.

Hongji Lee Bessler L.Ac.
POINT Acupuncture | Asian Medicine
2565 Hamline Avenue N.
Suite B
Roseville, MN 55113
651-699-2002

If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to the U.S. Department of Health and Human Services. *DDHS (Office of Civil Rights), 200 Independent Avenue SW, Room 509F HHH Building, Washington, D.C 20201.*

BY SIGNING BELOW, I CONFIRM THAT I HAVE READ AND UNDERSTAND THE STATEMENT OF PRIVACY POLICY FOR HEALTH CARE SERVICES IN THIS OFFICE.

_____ _____

PATIENT SIGNATURE **DATE**

☐ Check box if you would like a copy of this Privacy Policy.