NOTICE OF PRIVACY PRACTICES

Effective Date: MAY 25, 2016

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.

If you have any questions about this notice, please contact:
The CLINIC MANAGER
OR CURRENT HIPAA OFFICER FOR
BAKER ALLERGY, ASTHMA & DERMATOLOGY
9495 SW LOCUST ST, SUITE A
PORTLAND, OREGON 97223
503-636-9011

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff, and other personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from BAKER ALLERGY, ASTHMA & DERMATOLOGY. Your health information may include information created and received by BAKER ALLERGY, ASTHMA & DERMATOLOGY, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff, or other personnel who are involved in taking care of you and your health.

  For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

  Different personnel in our organization may share information about you and disclose information to people who do not work for BAKER ALLERGY, ASTHMA & DERMATOLOGY in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

  For payment. We may use and disclose health information about you so that the treatment and services you receive at BAKER ALLERGY, ASTHMA & DERMATOLOGY may be billed to and payment may be collected from you, an insurance company or a third party.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

- **For Health Care Operations.** We may use and disclose health information about you in order to run BAKER ALLERGY, ASTHMA & DERMATOLOGY and make sure that you and our other patients receive quality care.

  For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

  We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate, and manage health care and services, train staff and comply with the law.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Required by Law.** We will disclose health information about you when required to do so by federal, state, or local law.

- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

- **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

- **Military, Veterans, National Security, and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose health information about you for public health reasons to prevent or control disease, injury or disability, or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed.

  In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially protected information such as substance abuse information for purposes such as treatment, payment, and healthcare operations.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to the Clinic Manager in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

  If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing to the Clinic Manager. You have the right to request a copy of your health information in electronic form if we store your health information electronically.

  We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by BAKER ALLERGY, ASTHMA & DERMATOLOGY.

  To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to the Clinic Manager.

  We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

  - We did not create, unless the person or entity that created the information is no longer available to make the

amendment.

- Is not part of the health information that we keep.
- You would not be permitted to inspect and copy.
- Is accurate and complete.

If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be 3 pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions, and law enforcement.

To obtain this list, you must submit your request **in writing** to the Clinic Manager. Your request must state a specific time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

  We are required to agree to your request if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law.

  To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to the Clinic Manager.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to the Clinic Manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. [*You may also find a copy of this Notice on our web site.]*

  To obtain such a copy, contact the Clinic Manager.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. {*If a direct care provider* - We will post the current notice at our location(s) with its

effective date on the top. You are entitled to a copy of the notice currently in effect.

We will inform you of any significant changes to this Notice. This may be through our newsletter, a sign prominently posted at our location(s), a notice posted on our web site or other means of communication.

BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:

Office for Civil Rights
U.S. Department of Health and Human Services
2201 Sixth Avenue - M/S: RX-11
Seattle, WA 98121-1831
Voice Phone (800) 368-1019
FAX (206) 615-2297
TDD (800) 537-7697

To file a complaint with BAKER ALLERGY, ASTHMA & DERMATOLOGY, contact the CLINIC MANAGER at 503 636 9011. ***You will not be penalized for filing a complaint.***

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have access to a copy of the

BAKER ALLERGY, ASTHMA & DERMATOLOGY

Notice of Privacy Practices

By signing below, I agree that I have access to a copy of the Notice of Privacy Practices through the website and through hard copies conveniently located in the lobby of the clinic.

_____ _____
Patient Signature Date

_____
Print Patient Name

-OR-

_____ _____
Parent, Guardian, Responsible Party, Legal Representative Signature Date

_____
Description of Representative's Authority

NOTICE OF REFERRAL RIGHTS AND ACKNOWLEDGEMENT

THIS NOTICE DESCRIBES YOUR REFERRAL RIGHTS WHEN YOUR HEALTH CARE PROVIDER REFERS YOU TO ANOTHER PROVIDER OR FACILITY FOR ADDITIONAL TESTING OR HEALTH CARE SERVICES.

In accordance with Oregon law, when you are referred for care outside of our clinic, we at Baker Allergy, Asthma & Dermatology, are required to notify you that you may have the test or service done at a facility other than the one recommended by your physician or health care provider.

Oregon law says (ORS 441.098):

- A referral for a diagnostic test or health care treatment or service shall be based on the patient's clinical needs and personal health choices.
- A health practitioner shall not deny, limit, or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.
- A health practitioner or the practitioner's designee shall provide notice of patient choice at the time the patient establishes care with the practitioner and at the time the referral is communicated to the patient.
- The oral or written notice of patient choice shall clearly inform the patient:
  (a) That when referred, a patient has a choice about where to receive services; and
  (b) Where the patient can access more information about patient choice.
- The patient has a choice and when referred to a facility for a diagnostic test or health care treatment or service the patient may receive the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.
- If the patient chooses to have the diagnostic test, health care treatment or service at a facility different from the one recommended by a practitioner, the patient is responsible for determining the extent of coverage or the limitation on coverage for the diagnostic test, health care treatment or service at the facility chosen by the patient.
- **By signing below, I acknowledge that I have read and understand my referral rights as outlined above.**

_____ _____
Patient Signature Date

_____
Print Patient Name

-OR-

_____ _____
Parent, Guardian, Responsible Party, Legal Representative Signature Date

_____
Description of Representative's Authority

JAMES W. BAKER, MD, LLC
DBA: BAKER ALLERGY, ASTHMA & DERMATOLOGY

PATIENT RESPONSIBILITY FOR PAYMENT

To reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have questions about the policy, please discuss them with our business manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Baker Allergy, Asthma & Dermatology will submit charges for medical treatment to the patient's insurance company and where applicable, to Medicare. However, the patient is primarily responsible for paying any and all medical expenses incurred at the clinic.

Baker Allergy, Asthma & Dermatology does not verify in advance the patient's insurance. Patients should contact their insurance companies directly for any coverage questions they may have. If the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the deductible and whatever amounts the insurance company does not pay.

If the patient participates in an Oregon Health Plan program, the patient will be responsible for notifying the office at the time of service. If the patient participates in Washington DSHS, the patient will be responsible for all services. Baker Allergy, Asthma & Dermatology does not accept Washington DSHS.

Baker Allergy, Asthma & Dermatology does not treat worker's compensation injuries or illnesses. If the patient is involved in a motor vehicle or liability accident, the patient is responsible for paying all medical costs even if there is a pending lawsuit

If the patient participates in a plan that requires co-payment, the patient must pay the co-payment at the time of the appointment.

Contractual Agreement to Pay Medical Expenses

I understand that I am personally responsible for all medical expenses incurred at Baker Allergy, Asthma & Dermatology for medical care and treatment. I agree to pay all medical expenses within 90 days of the date those expenses were incurred.

Patient Responsibility (Disclaimer)

I understand that my insurance plan may require a referral from my Primary Care Physician to cover the visits to a Specialty Physician. If Baker Allergy, Asthma & Dermatology at this time has not received verification that a referral was obtained for services, and, if my insurance company denies payment, I agree that I will be financially responsible for all charges incurred (including lab and Xray).

I hereby assign to Baker Allergy, Asthma & Dermatology all insurance benefits due me to the fullest extent of my financial obligation. I authorize them and the physician to release to the insurance company any information acquired during my examination and treatment.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Baker Allergy, Asthma & Dermatology to release to my insurance company any information acquired during my examination or treatment. I also agree to full responsibility for all expenses incurred by or on account of myself or this patient and hereby assign to Baker Allergy, Asthma & Dermatology all insurance benefits due to the fullest extent of my financial obligation to said office.

_____ _____

Patient Signature (Parent or Guardian if patient is a minor) Date

_____

Patient Printed Name (or printed name of Parent or Guardian if patient is a minor)

_____

Address of Guarantor

Baker Allergy, Asthma and Dermatology

9495 SW Locust Street, Suite A
Portland, OR 97223

Patient Information

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Communication Preferences

Preferred contact phone number _____

□ Consent to leave detailed voice message
□ Consent to text

HIPAA Privacy Authorization

I understand that Baker Allergy Asthma and Dermatology may still use and disclose protected health information as indicated in the Notice of Privacy Practices.

Would you like to give someone else access to your medical records?

□ Yes, I would like to give access to the following friends, family, or caregivers: □ No

Full Name (First and Last) or Entity _____ Address _____ Relationship _____	Phone _____	Authorized to Disclose: □ Access to medical information (i.e., appointments, diagnoses, treatment plans, chart notes, test results) □ Access to billing information (i.e., balances, payment plans, claims processing, receipts)
Full Name (First and Last) or Entity _____ Address _____ Relationship _____	Phone _____	Authorized to Disclose: □ Access to medical information (i.e., appointments, diagnoses, treatment plans, chart notes, test results) □ Access to billing information (i.e., balances, payment plans, claims processing, receipts)

- This Authorization is being granted at the request of the individual.
- Unless otherwise revoked, this Authorization expires 12 months after the date of signing this form.
- I understand that I have the right to revoke this Authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.
- I understand that I have the right to refuse to sign this Authorization and that my treatment will not be conditioned on signing.
- I understand that information used or disclosed as a result of this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I release Baker Allergy, Asthma & Dermatology, their employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature of the Patient _____ Date _____

Signature of the Legal Representative _____ Relationship to Patient _____

BAKER
ALLERGY · ASTHMA
DERMATOLOGY

Information about Nondiscrimination and Accessibility

Nondiscrimination Statement: Discrimination is Against the Law

This office (James W. Baker, MD, LLC dba Baker Allergy, Asthma, and Dermatology) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Baker Allergy, Asthma, and Dermatology does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Baker Allergy, Asthma, and Dermatology:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Office Manager at 503-636-9011.

If you believe that Baker Allergy, Asthma, and Dermatology has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Office Manager, Civil Rights Coordinator
Baker Allergy, Asthma & Dermatology
9495 SW Locust St. Ste. A Portland, OR 97223
P: 503-636-9011, F: 503-636-3952

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Office Manager and Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.