DAYTON PSYCHIATRIC ASSOCIATES

627 Edwin C. Moses Blvd. 3rd Fl. Suite G, Dayton, Ohio-45417
Phone # 937-424-1000 Fax # 937-424-1002

Notice of HIPPA 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.

Our Responsibility The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care. It also includes bills, insurance claims, or other payment information that we maintain related to your care. This Notice describes how we handle your health information. We are required to maintain the privacy of your health information as required by law, provide you with this Notice of our duties and privacy practices regarding the health information about you that we collect, and maintain and follow the terms of our Notice currently in effect.

Uses and Disclosures of Information Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations. Participants in this organized health care arrangement also share health information with each other, as necessary to carry out treatment, payment, or health care operations related to the organized health care arrangements. We may share the minimum amount of personal health information necessary with business associates performing services on our behalf.

We are also permitted to use and disclose personal health information as required by the FDA, during an investigation by law and enforcement agencies, health oversight activities and other public health activities to the extent permitted under HIPPA.
Before using or disclosing your personal health information for any other purpose not identified above, we will obtain your written authorization. Unless action has already been taken in compliance with the authorization, you have a right to revoke such authorization by submitting your written request to us.

Your Health Information Rights

You have right to request to review, or receive a copy of, the health information about you that is maintained in our files. We reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. You can also request that we communicate with you by alternative means, such as making records available for pickup, or mailing them to your alternative address. We will accommodate reasonable request for such confidential communications. You can also request a list of our disclosures of your health information.
If we are unable to satisfy your request, we will tell you the reason for the denial and your right, if any, to request a review of the decision.

You have right to request a paper copy of this Notice.

Contact Information

After reviewing this Notice, if you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communication to our office at 937-424-1000.

I hereby authorize: Name:______________________ Relationship to patient ___________________
To have access to my medical records and any information that pertains to my treatment at Dayton Psychiatric Associates.*

HIPPA ACKNOWLEDGEMENT

I acknowledge that I have completely read and understand all the information presented to me in the Notice of Privacy Practices of Amita R. Patel M.D. Inc. dba Dayton Psychiatric Associates.

Signature ____ Date ____________________________________

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Amita R. Patel, M.D. Amarjeet S. Birdi, M.D. Shawn Breeding, P. A.
Martha Ann Cordasco, LISW Jeanne Sommer, Ph. D.

AUTOMATED PHONE REMINDERS

Dear Patient,
As part of our service to you, we have implemented an automated phone appointment reminder system. If you are interested in this service please provide us with your primary phone number below. Kindly note that if you have Privacy manager or DO NOT have an answering machine, this service will not be available to you. Also, this is a **courtesy service only** and you are requested to keep your appointment card as confirmation of your appointment. We thank you for your cooperation.

Phone No.____

AUTHORIZATION FOR TREATMENT

I hereby authorize Dayton Psychiatric Associates' professionals to evaluate and provide medical/ psychiatric services and treatment to me and to furnish this information to insurance carriers concerning my illness.

I hereby authorize payment directly to the physician or organization for providing medical/psychiatric services, otherwise payable to me under terms of my insurance. I hereby guarantee payment for all charges incurred for this account. I hereby acknowledge that insurance claims will be filed directly to my insurance company or employer.

I give Dayton psychiatric Associates permission to receive the medication history from any prescriber.

I acknowledge that any practitioner of Dayton Psychiatric Associates is not responsible for the actions or lack of action by any other practitioner from whom I may receive treatment or care.

PATIENT'S SIGNATURE ____ **DATE** __________________________