TICK BORNE DISEASE CENTER
OF SOUTHEASTERN PENNSYLVANIA

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY AND IF YOU HAVE ANY QUESTONS ABOUT THE NOTICE, PLEASE CONTACT OUR PRIVACY OFFICER.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" (or "PHI" for short) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services including the payment for your health care.

We are required by law to maintain the privacy of your PHI and to provide you with this notice informing you of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices at the time of your next appointment. We will also post the revised notice in our office.

I. Uses and Disclosures of Protected Health Information

A. We may use and disclosure your PHI for treatment, payment and health care operations. Your PHI may be used and disclosed by your health care provider and our office staff for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of our practice.

Following are examples of the types of uses and disclosures of your PHI that our office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

1. We may use and disclose your PHI to provide health care treatment. We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we may disclose your PHI to others when we order a laboratory study or an x-ray or when we call in a prescription for you.

In addition, we may disclose your PHI from time-to-time to another physician or health care provider such as a specialist who, at our request, becomes involved in your care by assisting your health care provider with your health care diagnosis or treatment.

2. We may use and disclose PHI in order to obtain payment for services. Our office may also need to use and disclose your PHI to others in order to bill and collect payment for the treatment and other services we provide to you. Before certain services are provided to you, we may need to share some of your PHI with your health plan. For example, we may need to verify coverage or to obtain pre-approval for studies and other tests in order for your health plan to pay for them.

We may also disclose identifiable health information to obtain payment from third parties such as insurance companies or family members that may be responsible for payment.

3. We may use and disclose PHI for our health care operations. We may use or disclose your PHI in order to support the business activities of our practice which we call "health care operations." These health care operations allow us to improve the quality of care we provide and reduce health care costs.

Examples of the way we may use or disclose PHI about you for "health care operations" include, but are not limited to, reviewing the quality of services we provide to you, evaluating our professional and business staff, having medical residents or students train in our office and conducting or arranging for other business activities.

We may also contact you to remind you of your next appointment with us or to provide you with information about treatment alternatives or services that may be of interest to you. We may also ask that you use a sign-in sheet at the registration desk when you come in for your appointment. We may also call you by name in the waiting room when your health care provider is ready to see you.

We may also share your PHI with third party "business associates" that perform certain activities for us or provide a service to us. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We will disclose identifiable health information only to the extent reasonably necessary to perform the above-mentioned activities of our practice. In some instances, we may need to use or disclose all of the information, while other times, we may need to use or disclose only certain information.

B. You may agree or object to certain uses and disclosures we may make. If you agree, we may disclose your PHI in the following instances. You may object to the use or disclosure of all or part of your PHI. If the opportunity to object to uses and disclosures cannot practically be provided because of your incapacity or in an emergency treatment circumstance, your health care provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

1. We may disclose PHI to others involved in your health care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care, of your location, general condition or death.

2. We may disclose PHI for disaster relief purposes. We may use or disclose your PHI to a public or private agency authorized by law or charter to assist in disaster relief efforts such as the American Red Cross.

C. We may use or disclose your PHI in other situations without your authorization.

1. Required by Law. We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

2. Public Health. We may disclose your PHI for public health activities and purposes to a public health authority that is authorized by Pennsylvania law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. For example, we are required under Pennsylvania law to report the presence of certain bacteria in laboratory tests, or the results of a positive Lyme test.

If we are examining or treating you at the request of your employer, we will disclose your PHI that consists of findings we obtained during this examination/treatment to your employer.

We may also disclose your PHI to an individual associated with the FDA in the event of a drug recall or to report a side effect or adverse event.

We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

3. Health Oversight. We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, civil, administrative or criminal investigations, inspections, and licensing activities.

4. Abuse or Neglect. Pennsylvania law requires that we report cases of child abuse to a government authority, if we have reasonable cause to suspect that a child is the victim of abuse. In addition, we may disclose your PHI if we believe that you (as an adult) are a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and Pennsylvania laws.

5. Judicial and Administrative Proceedings. We may disclose your PHI in response to a court order. All disclosures will be made consistent with the requirements of applicable federal and Pennsylvania law.

6. Law Enforcement. We may also disclose PHI so long as applicable legal requirements are met at the official request of law enforcement officials under the following circumstances:(a) the reporting of certain types of injuries, (b) limited information requests for identification and location purposes, (c) if you are or may be a victim of a crime, (d) suspicion that your death has occurred as a result of criminal conduct, (e) in the event that a crime occurs on the premises of our practice, and (f) if we provide medical care in response to a medical emergency and it is likely that a crime has occurred.

7. Coroners and Funeral Directors. We may disclose PHI to a coroner or medical examiner for identification purposes to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his duties.

8. Organ Donation. PHI may be used and disclosed to organ procurement organizations for cadaveric organ, eye or tissue donation purposes.

9. Research. If we disclose your PHI for research, we will comply with federal and Pennsylvania law regarding such disclosures. An authorization will also be obtained from you.

10. To Avert Serious Threat. We may disclose your PHI if we believe in good faith that the use or disclosure is necessary to prevent or reduce a serious and imminent threat to the health and safety of another person or the public. Under these circumstances, we will only disclose health information to someone who is able to help prevent or lesson the threat.

11. For Government Functions. Consistent with applicable federal laws, we may disclose your PHI if you are a member of the Armed Forces: (a) for activities deemed necessary by appropriate military command authorities; (b for the purpose of a determination by the Department of Veteran Affairs of your eligibility for benefits; or (c) to a foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others individuals. Also, we may disclose to a correctional institution or law enforcement officials having legal custody of the inmate.

12. Workers' Compensation. Your PHI may be disclosed by us as authorized to comply with worker's compensation laws and other similar government programs that provide public benefits.

D. We are required to disclose your PHI upon request to the Secretary of HHS. We are required to disclose your PHI to the Secretary of Health and Human Services to investigate or determine our compliance with the Privacy Regulations.

E. All other disclosures require your written authorization. Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

II. Your Rights.

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

A. You Have the Right to Request a Restriction of Your Protected Health Information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If we agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. Please discuss any restriction you wish to request with our Privacy Officer.

B. You Have the Right to Receive Confidential Communications of PHI from us by Alternative Means or at an Alternative Location. We will accommodate reasonable requests. We may also condition this accommodation, if appropriate, by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please contact our Privacy Officer to make such a request.

C. You Have the Right to Inspect and Copy Your PHI. This means you may inspect and obtain a copy of your PHI that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" includes medical and billing records and any other records that our practice uses for making decisions about you.

You may not inspect or obtain a copy of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to protected health information. To discuss your right to inspect and copy your PHI, please see our Privacy Officer.

D. You Have the Right to Have Your Physician Amend Your PHI. You may request that we amend your PHI in a designated record set for as long as we maintain this information. All requests should be in writing. Please speak with the Privacy Officer if you have any questions or would like to request an amendment of your PHI.

E. You Have the Right to Receive an Accounting of Certain Disclosures We Have Made, if any, of Your PHI. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It also excludes disclosures we may have made to you or for which we have an authorization from you and disclosures made to family members or friends involved in your care. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. Please contact our Privacy Office to request an accounting.

F. You Have the Right to Obtain a Paper Copy of this notice From Us. You have the right to receive a paper copy of this notice upon request, even if you have agreed to accept this notice electronically.

III. Complaints

You have the right to complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not take any action against you or deny you medical care for filing a complaint.

You may contact our Privacy Officer June Spohn at (610) 235-4105 or for further information about the complaint process.

You may contact the Secretary of Health and Human Services at the following address and telephone number:

Office for Civil Rights
U.S. Department of Health and Human Services
150 S. Independence Mall West
Suite 372, Public Ledger Building
Philadelphia, PA 19106-9111
(800) 368-1019

ACKNOWLEDGEMENT OF RECEIPT

OF THE NOTICE OF PRIVACY PRACTICE

I have received a paper copy of the **TICK BORNE DISEASE CENTER OF SOUTHEASTERN PENNSYLVANIA** Notice of Privacy Practices.

Name:_____

Signature:_____

Date:_____

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ OCCUPATION: _____

CITY, STATE, ZIP:_____ EMPLOYER:_____

TELEPHONE

HOME (_____) _____ MEDICAL INSURANCE: _____

WORK (_____) _____ AGREEMENT/ID#:_____

CELL (_____) _____ GROUP #:_____

MARITAL STATUS:_____ SUBSCRIBER:_____

HEIGHT: _____ SUBSCRIBER DATE OF BIRTH: _____

WEIGHT: _____ BMI: _____ PERSONAL MEDICAL HISTORY

ALLERGIES TO MEDICATIONS AND SEASONAL HYPERTENSION: _____

1._____ DIABETES: _____

2. _____ OTHER: _____

3. _____ _____

MEDICATIONS (CURRENT) FAMILY MEDICAL HISTORY

1. _____ 2. _____ LIVING OR DECEASED ILLNESS

3. _____ 4. _____ FATHER: _____ _____

5. _____ 6. _____ MOTHER: _____ _____

SURGICAL HISTORY SISTER(S): _____ _____

1. _____ 2. _____ BROTHER(S): _____ _____

3. _____ 4. _____ GRANDPARENTS: _____ _____

5. _____ 6. _____ OTHERS: _____ _____

VISION EXAM – DATE: _____ STREET DRUG USE Y/N _____ NAME OF DRUG(S)

DENTAL EXAM – DATE: _____ _____

MAMMOGRAPHY –DATE(S):_____ __I AM __ I WAS A SMOKER_____PACKS A DAY

PSA – DATE(S):_____ CIGARETTES_____ CIGARS_____ PIPE_____

PAP – DATE(S):_____ DATE (IF) STOPPED SMOKING _____

COLONOSCOPY – DATES _____ ALCOHOL_____ TIMES PER WEEK

HEMOCCULT TESTING – DATE(S) _____ COFFEE/TEA/SODA (CAFFEINE) _____ PER DAY

TETANUS – DATE _____ LIVING WILL (Y/N) _____ EXERCISE _____

FLU VACCINE – DATE(S) _____

PNEUMONIA VACCINE – DATE(S) _____

FOR CHILDREN-VACCINES UP TO DATE: _____

(PLEASE PROVIDE A COPY OF IMMUNIZATION RECORD) RECEIVED/REVISED (DATE) _____

915 Old Fern Hill Road, Bldg D, Ste 500
West Chester, Pa 19380
TELEPHONE: (610) 235-4105 FAX: (610) 235-4108

THIS OFFICE HAS ESTABLISHED FEES FOR PROFESSIONAL SERVICES TO OUR PATIENTS. THE RESPONSIBILITY FOR PAYMENT OF THESE FEES IS THE DIRECT OBLIGATION OF THE PATIENT. ANY FINANCIAL BENEFIT THE PATIENT MAY RECEIVE FROM THE INSURANCE OR GOVERNMENT AGENCIES IS A MATTER OF SETTLEMENT SOLELY BETWEEN THE PATIENT AND INSURANCE CARRIER OR GOVERNMENT AGENCY. WE WOULD APPRECIATE IF YOU WOULD BE PREPARED TO TAKE CARE OF YOUR ACCOUNT AT THE TIME OF THE OFFICE VISIT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. WE THANK YOU FOR YOUR COOPERATION.

PLEASE READ AND SIGN:

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN

I hereby authorize payment directly to the Tick Borne Disease Center of Southeastern Pennsylvania, the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described in the Physician's Bill, but not to exceed the charges stated in the Physician's Bill. I understand that I am responsible to the Tick Borne Disease Center of Southeastern Pennsylvania, for charges that are not covered by insurance, and that over payments will be refunded to the responsible party.

_____ _____

SIGNATURE **DATE**

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Tick Borne Disease Center of Southeastern Pennsylvania to release any information acquired in the course of my examination or treatment to my insurance company.

_____ _____

SIGNATURE **DATE**

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION: _____

INITIALS PLEASE

915 Old Fern Hill Road, Bldg D, Ste 500
West Chester, Pa 19380
TELEPHONE: (610) 235-4105 FAX: (610) 235-4108

DISCLAIMER

I understand that the blood tests for Lyme Disease (Lyme ELISA titer and Lyme Western Blot) are considered indicative, but not diagnostic of Lyme Disease. I understand that the diagnosis of Lyme Disease is based on clinical diagnosis which is based upon the representing signs and symptoms. I understand that Lyme Disease can mimic other diseases and that false positive and false negative diagnosis can occur.

I understand and accept the above and do consent to treatment for Lyme Disease with oral and/or intravenous antibiotics as considered necessary by Dr. Schuchman, who has reviewed with me the possible benefits and risks associated with the treatment plan.

_____

SIGNATURE

_____

WITNESS

_____

DATE

915 Old Fern Hill Road, Bldg D, Ste 500
West Chester, Pa 19380
TELEPHONE: (610) 235-4105 FAX: (610) 235-4108

To Our Patients:

As you are aware, there are many HMO and PPO organizations forming along with standard health insurances. Since these organizations have very specific rules governing the administration of your particular plan, it is no longer possible to assume that if you have a particular insurance carrier, all our patients with this same carrier have the same coverage. Each employer picks and chooses the exact plan their company will offer their employees. With this in mind, it is impossible for our office to be aware of all the specific guidelines each Insurance Company, HMO, or PPO requires. For example, one carrier may use a specific laboratory for testing, while another may pay for the testing no matter which laboratory is used.

We will continue to cooperate with you in any way possible to accommodate your carrier, but it is **YOUR RESPONSIBILITY** to know exactly what your coverage requires. We cannot be responsible to know which carrier needs a referral, a specific form to be submitted, or pre-approval of services. Please give us **ALL** your insurance information at your initial visit, and we will do our best to work with you and your carrier.

Remember, call your carrier or consult your handbook to determine what your coverage guidelines are.

THANK YOU,

I fully understand the above and have furnished all of my insurance information.

Signed:_____ Date:_____

TICK BORNE DISEASE CENTER OF SOUTHEASTERN PENNSYLVANIA
915 Old Fern Hill Road, Bldg D, Ste 500
West Chester, Pa 19380
TELEPHONE: (610) 235-4105 FAX: (610) 235-4108

To Doctor/Facility:_____

Address:_____

City, State, Zip_____

Authorization to Request Protected Health Information

Patient Name :_____ D.O.B._____/_____/_____

Address:_____

City, State, Zip:_____ S.S.# _____-_____-_____

Purpose for Disclosure: For completeness of Medical History and to allow for proper evaluation of the patient.

Treatment Dates: _____

( ) Entire Medical Record

( ) Admission Record	( ) Operative Record	( ) Laboratory
( ) Discharge Summary	( ) Pathology Report	( ) Doctor's Orders
( ) Emergency Report	( ) Radiology/Nuclear Med	( ) Doctor's Progress Notes
( ) History & Physical	( ) EKG/ Cardiology	( ) Other, Specify _____
( ) Consultation (s)	( ) Vascular Studies	_____

I do hereby consent to and authorize disclosure to the name above to release information from my medical records relating to my identity, diagnosis, prognosis, treatment and condition, including:
psychological or psychiatric impairment; drug abuse and/or alcoholism; sickle cell anemia; and acquired immunodeficiency syndrome (AIDS) and/or tests for infection with (HIV).

Release is to be limited to the specified report (s) within the specified date (s) of treatment detailed above. I understand that this consent shall operate as a complete release of liability from the organization, its trustees, officers, agents and employees for the release of information as specified above.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient noted above and in that case, will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I understand that HIPPA, and its implementing regulations (HIPPA) govern the terms of this authorization. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I do not revoke this consent, it will terminate six (6) months from the date of my signature. I understand authorizing to release the use or disclosure of my information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____/_____/_____
(Patient / Guardian / Designee-Signature) Date

_____
(Relationship to Patient)

PLEASE PROVIDE A COPY OF THIS REQUEST TO THE PATIENT

915 Old Fern Hill Road, Bldg D, Ste 500
West Chester, Pa 19380
TELEPHONE: (610) 235-4105 FAX: (610) 235-4108

Waiver For Out-Of-Network Labs

I _____ am aware that my insurance may not cover the entire lab expenses that will accrue.

I am aware that I will be responsible/liable for any balances due.

_____
Signature

_____
Witness

_____
Date

915 Old Fern Hill Road, Bldg D, Ste 500
West Chester, Pa 19380
TELEPHONE: (610) 235-4105 FAX: (610) 235-4108

PATIENT INTAKE FORM

NAME:_____ **DATE: _____/_____/_____**

PRIVATE MEDICAL
DOCTOR:_____

ADDRESS:_____

PHONE #:_____

OTHER DOCTORS YOU HAVE SEEN
REGARDING THIS
DISEASE_____

SYMPTOMS:

EARLY:	YES	NO	UNKNOWN	COMMENTS
Tick or Insect Bite				
Rash				
Chills				
Fever				
Sore Throat				
Flu-like Symptoms				
EARLY TO LATE:				
Headache				
Diarrhea				
Nausea/Vomiting				
Irregular heart beats/palpitations				
Chest pain				
Shortness of breath				
Pneumonia				
Jaw pain/pain with chewing				
Neck and/or back pain				
Joint pain				
Muscle aches/cramps/pain				
Stiff neck				

LATE:	YES	NO	UNKNOWN	COMMENTS
Fatigue				
Visual Disturbances				
Hearing Problems				
Ringing in Ears				
Facial weakness/palsy				
Numbness/tingling sensations				
Forgetfulness				
Lack of concentration:				
Change in ability to think,				
work with numbers,				
spell or remember words				
Recurring rashes				
Nodules on skin				

Were you diagnosed during Pregnancy?_____

Outcome of the Pregnancy?_____

Were you treated during the pregnancy?_____

Have you ever been treated for Lyme Disease?_____

DRUG: ORAL	YES	NO	UNKNOWN	COMMENTS
Penicillin				
Amoxicillin				
Probenecid				
Doxycycline				
Tetracycline				
Ceftin				
Suprax				
Biaxin				
Zithromax				
Ampicillin				
INTRAVENOUS:				
Penicillin				
Rocephin				
Claforan				
Vancomycin				
Other				

How long were you treated? _____

Signature _____