DEFY
THERAPY & WELLNESS

15807 Biscayne Blvd #113, N. Miami Beach, FL 33160, T. 786.955.6912, F. 786.955.6956
Email: info@defytherapyandwellness.com
defytherapyandwellness.com

SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES (NPP)

THIS NOTICE DESCRIBES HOW HEALTH 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 OR COMMENTS ABOUT THIS NOTICE PLEASE CONTACT DEFY THERAPY & WELLNESS.

WHO WILL FOLLOW THIS NOTICE:

Defy Therapy & Wellness
15807 Biscayne Blvd #113
North Miami Beach, FL 33160

PHONE: (786) 955-6912
FAX: (786) 955-6956

THIS NOTICE DESCRIBES OUR PRIVACY PRACTICES. ALL THE ENTITIES, AND LOCATIONS FOLLOW THE TERMS OF THIS NOTICE. IN ADDITION, THESE ENTITIES, AND LOCATIONS MAY SHARE PHI WITH EACH OTHER FOR THE PURPOSES OF TREATMENT, BILLING OR HEALTHCARE OPERATION PURPOSES DESCRIBED IN THIS NOTICE.

WE ARE REQUIRED BY LAW: TO MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION AND TO PROVIDE YOU WITH NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO YOUR HEALTH INFORMATION. WE ARE REQUIRED BY LAW TO FOLLOW THE TERMS AND CONDITIONS OF THE EFFECTIVE NOTICE.

WE MAY DISCLOSE YOUR HEALTH INFORMATION: FOR APPOINTMENT REMINDERS, TO OTHER HEALTHCARE PROFESSIONALS WITHIN OUR PRACTICE FOR THE PURPOSE OF TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS. WE MAY DISCLOSE YOUR HEALTH INFORMATION TO YOUR INSURANCE PROVIDER FOR PAYMENT/HEALTHCARE OPERATIONS, TO COMPLY WITH STATE WORKERS' COMPENSATION LAWS, TO NOTIFY A FAMILY MEMBER IN THE EVENT OF AN EMERGENCY, AND/OR AS REQUIRED BY LAW AND/OR TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY.

YOU HAVE THE FOLLOWING RIGHTS TO YOUR PHI RECORDS: YOU HAVE THE RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES/DISCLOSURES OF YOUR PHI AND AMENDMENTS TO YOUR PHI, HOWEVER, WE ARE NOT REQUIRED TO AGREE TO THE RESTRICTIONS AND/OR AMENDMENTS YOU REQUESTED. YOU HAVE THE RIGHT TO HAVE YOUR PHI RECEIVED/COMMUNICATED THROUGH AN ALTERNATIVE METHOD OR LOCATION UPON YOUR REQUEST. YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PHI, TO A COPY OF THIS NOTICE, TO REQUEST CONFIDENTIAL COMMUNICATIONS, AND YOU HAVE THE RIGHT TO REQUEST AN ACCOUNTING OF DISCLOSURE(S).

CHANGES TO THIS NOTICE: WE RESERVE THE RIGHT TO AMMEND THIS NOTICE OF PRIVACY PRACTICES AT ANY TIME IN THE FUTURE, AND WILL MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INFORMATION THAT WE MAINTAIN. UNTIL SUCH AMENDMENT IS MADE, WE ARE REQUIRED BY LAW TO COMPLY WITH THIS NOTICE.

COMPLAINTS ABOUT YOUR PRIVACY RIGHTS OR HOW WE HAVE HANDLED YOUR HEALTH INFORMATION SHOULD BE DIRECTED TO OUR PRIVACY OFFICE BY CALLING THE OFFICE (786) 955-6912 OR MAKE AN APPOINTMENT FOR AN IN-PERSON CONFERENCE TO OCCUR WITHIN 2 WORKING DAYS. IF YOU ARE NOT SATISFIED WITH THE MANNER IN WHICH THIS OFFICE HANDLES YOUR COMPLAINT, YOU MAY SUBMIT, AT YOUR REQUEST, FORMAL COMPLAINT TO: DDHA, OFFICE OF CIVIL RIGHTS, 200 INDEPENDENCE AVE S.W, ROOM 509 F HHH BUILDING, WASHINGTON, DC 20201.

I HAVE READ THE PRIVACY NOTICE AND UNDERSTAND MY RIGHTS CONTAINED IN THE NOTICE. BY WAY OF MY SIGNATURE, I PROVIDE THE COMPANY ABOVE WITH MY AUTHORIZATION AND CONSENT TO USE AND DISCLOSE MY PROTECTED HEALTH CARE INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS AS DESCRIBED IN THE PRIVACY NOTICE.

_____ DOB: _____/_____/_____
PATIENT'S NAME (PRINT)

_____ DATE: _____/_____/_____
PATIENT'S / REPRESENATIVE'S SIGNATURE

_____ DATE: _____/_____/_____
AUTHORIZED FACILITY SIGNATURE

YOU HAVE A RIGHT TO A COPY OF THIS FORM AFTER YOU SIGN IT