

# WIKTORIA BIELSKA, M.D.

PSYCHIATRY

160 Broadway Suite 900, New York, NY 10038

T (646) 926-3162

## STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices, but will always inform you of any changes that might affect your rights.

## PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and the State of New York. This includes issues relating to your treatment, payment, and our healthcare operations. Your personal health information will never otherwise be given to anyone, even family members, without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

The HIPAA officer for this practice is Wiktorina Bielska.

## COLLECTING PROTECTED HEALTH INFORMATION

We will only request personal information needed to provide our standard of quality healthcare, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone numbers, social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

## DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machine messages, and postcards.

## PATIENT RIGHTS

You have the right to request copies of your healthcare information, to request copies in a variety of formats, and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

*Wiktorina Bielska, M.D.*

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND POLICIES

In order to comply with HIPAA standards, each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices and Policies or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or healthcare operations.

I have received a copy of the Notice of Privacy Practices and Policies from:

Wiktorija Bielska, M.D.  
160 Broadway Suite 900  
New York, NY 10038

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF OFFICE POLICIES AND PROCEDURES

I have received a copy of Wiktorija Bielska, M.D.'s Notice of Office Policies and Procedures. I understand and agree to abide by them and consent to receive treatment. I understand and agree to abide by the late cancellation and missed appointment policy, which stipulates that, unless agreed upon in advance, I owe the cost of a session if I cancel an appointment less than 7 days in advance.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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If you were unable to obtain an Acknowledgement of Receipt or unable to obtain a signature for the Acknowledgement of Receipt, please state the reason below. Please include your name.