NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

I. Our Duty to Safeguard Your Protected Health Information

We are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information. Copies of our privacy policies and procedures are maintained in the business office. We are required by state and federal regulations to abide by the privacy practices described in this notice including any future revisions that we may make to the notice as may become necessary or as authorized by law.

Individually identifiable information about your past, present, or future health or condition, the provisions of health care to you, or payment for the health care treatment or services you receive is considered *protected health information* (PHI). As such, we are providing you with this Privacy Notice. The Privacy Notice contains information regarding our privacy practices and explains how, when and why we may use or disclose your protected health information and your rights and our obligations regarding any such uses or disclosures. Except in specified circumstances, we will use or disclose only the minimum necessary protected health information to accomplish the intended purpose of the use or disclosure of such information.

We reserve the right to change this notice at any time and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future about you. Should we revise/change this Privacy Notice, we will post a copy of the new/revised Privacy Notice in the main lobby. You also may request and obtain a copy of any new/revised Privacy Notice from the business office.

Should you have questions concerning our Privacy Notices, the names, addresses, telephone numbers, website addresses, etc., of whom you should contact are listed on the last page of this document.

II. How We May Use and Disclose Your Protected Health Information

We use and disclose protected health information for a variety of reasons. We have a limited right to use and/or disclose your health information for purposes of treatment, payment, or for the operations of our facility. For other uses, you must give us your written authorization to release your protected health information unless the law permits or requires us to make the use or disclosure without your authorization.

Should it become necessary to release your protected health information to an outside party, we will require the party to have a signed agreement with us that the party will extend the same degree of privacy protection to your information as we do.

The privacy law permits us to make some uses or disclosures of your protected health information without your consent or authorization. The following describes each of the different ways that we may use or disclose your protected health information. Where appropriate, we have included examples of the different types of uses or disclosures. These include:

1. ***Use and Disclosures Related to Treatment:***

   We may disclose your protected health information to those who are involved in providing psychosocial/psychological, medical and nursing care services and treatments to you. For example we may release health information about you to our nurses, nursing assistants, medication aides/technicians, medical and nursing students, therapists, pharmacists, medical records personnel, consultants, physicians, etc. We may also disclose your protected health information to outside entities performing other services relating to your treatment; such as diagnostic laboratories, home health/hospice agencies, family members, etc.

2. ***Use and Disclosures Related to Payment:***

We may use or disclose your protected health information to bill and collect payment for services or treatments we provided to you. For example, we may contact your insurance facility, health plan, or another third party to obtain payment for services we provided to you.

3. Use and Disclosures Related to Health Care Operations:

We may use or disclose your protected health information to perform certain functions within our facility should these uses or disclosures become necessary to operate our facility and to ensure that you and others we provide care and group therapy services to continue to receive quality care and services. For example, we may take your photograph for medication identification purposes or use your health information to evaluate the effectiveness of the care and services you are receiving. We may disclose your protected health information to our staff (nurses, nursing assistants, physicians, staff consultants, therapists, etc.) for auditing, care planning, treatment, and learning purposes. It is also our requirement that group therapy discussions are kept confidential and not discussed outside of the therapy venue. We may also combine your health information with information from other health care providers to study how our facility is performing in comparison to like facilities or what we can do to improve the care and services we provide to you. When information is combined, we remove all information that would identify you so that others may use the information in developing research on the delivery of health care services without learning your identity.

4. Use and Disclosures Related to Fundraising Activities:

We may use a limited amount of your protected health information when raising money for our facility and its operations. We may also disclose this information to a foundation related to the facility so that the foundation may contact you to raise money on behalf of our facility. The information we may use will be limited to your name, address, telephone number, and dates for which you received treatment or services at our facility. **If you do not wish to be contacted for participation in fundraising activities or have this information provided to our affiliated foundation, you must provide us with a written notification. The name of the person to contact and the method of contacting him/her are listed on the last page of this notice.** You may use our *Request to Restrict the Use and Disclosure of Protected Health Information* form to submit your request to us. Copies of this form are available in the business office. (See also Section VI, paragraph 1.)

5. Use and Disclosures Related to Treatment Alternatives, Health-Related Benefits and Services:

We may use or disclose your protected health information for purposes of contacting you to inform you of treatment alternatives or health-related benefits and services that may be of interest to you. For example, a newly released medication or treatment that has a direct relationship to the treatment or medical condition.

III. Uses and Disclosures Requiring Your Written Authorization

For uses and disclosures of your protected health information beyond treatment, payment and operations purposes, we are required to have your written authorization, except as permitted by law. You have the right to revoke an authorization at any time to stop future uses or disclosures of your information except to the extent that we have already undertaken an action in reliance upon your authorization. Your revocation request must be provided to us in writing. The name, address, telephone number of the person to contact is located on the last page of this document. You may use our *Authorization for Use or Disclosure of Protected Health Information* form and/or our *Revocation of an Authorization* form to submit your request to us. Copies of these forms are available in the business office.

Examples of uses or disclosures that would require your written authorization include, but are not limited to, the following:

1. A request to provide your protected health information to an attorney for use in a civil litigation claim.
2. A request to provide certain information to an insurance or pharmaceutical facility for the purposes of providing you with information relative to insurance benefits or new medications that may be of interest to you.
3. A request to provide certain information to another individual or facility.
4. A request to provide certain information for marketing purposes.
5. A request to sell certain information.

IV. Uses or Disclosures of Information Based Upon Your Choice and Verbal Agreement

In the following situations, we may disclose a limited amount of your protected health information if we provide you with an advance oral or written notice and you do not object to such release or such release is not otherwise prohibited by law. However, if there is an emergency situation and you are unable to object (because you were not present or you were incapacitated, etc.), disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest. When a disclosure is made based on these or emergency situations, we will only disclose health information relevant to the person's involvement in your care. For example, if you are sent to the emergency room, we may only inform the person that you suffered an apparent heart attack, stroke, etc., and/or we may provide information on your prognosis or progress. You will be informed and given an opportunity to object to further disclosures of such information as soon as you are able to do so.

1. **Information Used or Disclosed in a Facility Directory:**

   We may use or disclose your name, unit or room number, and religious affiliation in our facility directory. We may also disclose your religious affiliation to a member of the clergy. Information concerning your general condition or room location may be provided to callers or visitors when they ask for you by name. You may object to the release of this information. You may use our *Request to Restrict the Use or Disclosure of Protected Health Information* form to notify us of your objection or your objection may be made orally. The name, address, and telephone number of the person to whom you may make your objection is listed on the last page of this document. (See also Section VI, paragraph 1.)

2. **Information Disclosed to Family Members, Friends or Others Involved in Your Care:**

   We may disclose your protected health information to your family members and friends who are involved in your care or who help pay for your care. We may also disclose your protected health information to a disaster relief organization for the purposes of notifying your family and/or friends about your general condition, location, and/or status (i.e., alive or dead). You may object to the release of this information. You may use our *Request to Restrict the Use or Disclosure of Protected Health Information* form to notify us of your objection or your objection may be made orally. The name, address, and telephone number of the person to whom you may make your objection is listed on the last page of this document. (See also Section VI, paragraph 1.)

V. Uses and Disclosures of Information That Do Not Require Your Consent or Authorization

State and federal laws and regulations either require or permit us to use or disclose your protected health information without your consent or authorization. The uses or disclosures that we may make without your consent or authorization include the following:

1. **When Required by Law:**

   We may disclose your protected health information when a federal, state or local law requires that we report information about suspected abuse, neglect, or domestic violence, reporting adverse reactions to medications or injury from a health care product, or in response to a court order or subpoena.

2. **For Public Health Activities for the Purpose of Preventing or Controlling Disease, Injury or Disability:**

   We may disclose your protected health information when we are required to collect information about diseases or injuries (e.g., your exposure to a disease or your risk for spreading or contracting a communicable disease or condition, product recalls, or to report vital statistics (e.g., births/deaths) to the public health authority).

3. **For Health Oversight Activities:**

   We may disclose your protected health information to a health oversight agency such as a protection and advocacy agency, the state agency responsible for inspecting our facility or to other agencies responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents or to ensure that we are in compliance with applicable state and federal laws and regulations and civil rights issues.

4. **To Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations or Tissue Banks:**

   We may disclose your protected health information to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death. We may also disclose your health information to a funeral director for the purposes of carrying out your wishes and/or for the funeral director to perform his/her necessary duties.

If you are an organ donor, we may disclose your protected health information to the organization that will handle your organ, eye or tissue donation for the purposes of facilitating your organ or tissue donation or transplantation.

5. For Research Purposes:

We may disclose your protected health information for research purposes only when a privacy board has approved the research project. However, we may use or disclose your protected health information to individuals preparing to conduct an approved research project in order to assist such individuals in identifying persons to be included in the research project. Researchers identifying persons to be included in the research project will be required to conduct all activities onsite. If it becomes necessary to use or disclose information about you that could be used to identify you by name, we will obtain your written authorization before permitting the researcher to use your information. Researchers will be required to sign a *Confidentiality and Non-Disclosure Agreement* form before being permitted access to health information for research purposes. A sample copy of this agreement may be obtained from the business office.

6. To Avert a Serious Threat to Health or Safety:

We may disclose your protected health information to avoid a serious threat to your health or safety or to the health or safety of others. When such disclosure is necessary, information will only be released to those law enforcement agencies or individuals who have the ability or authority to prevent or lessen the threat of harm.

7. For Specific Government Functions:

We may disclose protected health information of military personnel and veterans, when requested by military command authorities, to authorized federal authorities for the purposes of intelligence, counterintelligence, and other national security activities (such as protection of the President), or to correctional institutions.

VI. Your Right Regarding Your Protected Health Information

You have the following rights concerning the use or disclosure of your protected health information that we create or that we may maintain on our premises:

1. To Request Restrictions on Uses and Disclosures of Your Protected Health Information:

You have the right to request that we limit how we use or disclose your protected health information 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 your care or services. For example, you could request that we not disclose to family members or friends information about a medical treatment you received.

Should you wish a restriction placed on the use and disclosure of your protected health information, you must submit such request in writing. (**Note**: You may submit such request using our *Request to Restrict the Use and Disclosure of Protected Health Information* form. Copies of this form are available in the business office.) The name, address, and telephone number of the person to whom the request is to be submitted is listed on the last page of this document.

You have the right to request that information about a test or treatment no be shared with an insurance company, if expenses associated with the test or treatment were paid out-of-pocket and not submitted to an insurance company for payment.

We are not required to agree to your restriction request. However, should we agree, we will comply with your request not to release such information unless the information is needed to provide emergency care or treatment to you.

2. The Right to Inspect and Copy Your Medical and Billing Records:

You have the right to inspect, receive a paper copy, or receive an electronic copy of your health information, such as your medical and billing records that we use to make decisions about your care and services. In order to inspect and/or receive a copy your health information, you must submit a written request to us. If you request a copy of your medical information, we may charge you a reasonable fee for the paper, labor, mailing, and/or retrieval costs involved in filing your requests. We will provide you with information concerning the cost of copying your health information prior to performing such service. The name, address, and telephone number of the person to whom you may file your request is listed on the last page of this document. You may submit your requests on our *Request for Inspection/Copy of Protected Health Information* form. Copies of these forms are available in the business office.

We will respond within thirty (30) days of receipt of such requests. Should we deny your request to inspect and/or copy your health information, we will provide you with written notice of our reasons of the denial and your rights for requesting a review of our denial. If such review is granted or is required by law, we will select a licensed health care professional not involved in the original denial process to review your request and our reasons for denial. We will abide by the reviewer's decision concerning your inspection/copy requests. You may submit your denial review requests on our *Denial of Inspection/Copy of Protected Health Information* form. Copies of these forms are available in the business office.

3. The Right to Amend or Correct Your Health Information:

You have the right to request that your health information be amended or corrected if you have reason to believe that certain information is incomplete or incorrect. You have the right to make such requests of us for as long as we maintain/retain your health information. Your requests must be submitted to us in writing. We will respond within thirty (30) days of receiving the written request. If we approve your request, we will make such amendments/corrections and notify those with a need to know of such amendments/corrections.

We may deny your request if:

a. Your request is not submitted in writing;
b. Your written request does not contain a reason to support your request;
c. The information was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
d. It is not a part of the health information kept by or for our facility;
e. It is not part of the information which you would be permitted to inspect and copy; and/or
f. The information is already accurate and complete.

If your request is denied, we will provide you with a written notification of the reason(s) of such denial and your rights to have the request, the denial, and any written response you may have relative to the information and denial process appended to your health information.

The name, address, and telephone number of the person to whom you may file your request is listed on the last page of this document. You may submit your amendment/correction requests on our *Request for Amendment/Correction of Protected Health Information* form. Copies of these forms are available in the business office.

4. The Right to Request Confidential Communications:

You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. For example, you may request that we not send any health information about you to a family member's address. We will agree to your request as long as it is reasonable for us to do so. You are not required to reveal nor will we ask the reason for your request. To request confidential communications you must:

a. Notify us in writing;
b. Indicate what information you wish to limit;
c. Indicate whether or not you wish to limit or restrict our use or disclosure of such information; and
d. Identify to whom the restrictions apply (e.g., which family member(s), agency, etc).

The name, address, and telephone number of the person to whom you may file your request is listed on the last page of this document. You may submit your requests on our *Request for Restriction of Confidential Communications* form. Copies of these forms are available in the business office.

5. The Right to Request an Accounting of Disclosures of Protected Health Information:

You have the right to request that we provide you with a listing of when, to whom, for what purpose, and what content of your protected health information we have released over a specified period of time. This accounting will not include any information we have made for the purposes of treatment, payment, or health care operations or information released to you, your family, or the facility directory, disclosures made for national security purposes, or any releases pursuant to your authorization.

Your request must be submitted to us in writing and must indicate the time period for which you wish the information (e.g., May 1, 2003 through August 31, 2005). Your request may not include releases for more than six (6) years **prior** to the date of your request and may not include releases **prior** to April 14, 2003. Your request must indicate in what form (e.g., printed copy or email) you wish to receive this information. We will respond to your request with sixty (60) days of the receipt of your written request. Should additional time be needed to reply, you will be notified of such extension. However, in no case will such extension exceed thirty (30) days. The first accounting you request during a twelve (12) month period will be free. There may be a reasonable fee for additional requests during the twelve (12) month period. 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.

The name, address, and telephone number of the person to whom you may file your request is listed on the last page of this document. You may submit your requests on our *Request for an Accounting of Disclosures of Protected Health Information* form. Copies of these forms are available in the business office.

6. The Right to Receive a Paper Copy of This Notice:

You have the right to receive a paper copy of this notice even though you may have agreed to receive an electronic copy of this notice. You may request a paper copy of this notice at anytime or you may obtain a copy of this information from our website (as applicable). The name, address, and telephone number of the person to whom you may obtain a paper copy of this notice is listed on the last page of this document.

7. The Right to Choose Someone to Act on Your Behalf:

If you have given someone medical power of attorney or if someone is you legal guardian, that individual can exercise your rights and make choices about your health information. We will ensure that individual has this authority and can act for you before we take any action.

VI. How to File a Complaint about Our Privacy Practices

If you have reason to believe that we have violated your privacy rights, violated our privacy policies and procedures, or you disagree with a decision we made concerning access to your protected health information, etc., you have the right to file a complaint with us or the Secretary of the Department of Health and Human Services. Complaints may be filed without fear of retaliation in any form.

The name, address, and telephone number of the person to whom you may file your complaint is listed on the last page of this document. You may submit your complaint on our Privacy Practices Complaint form. Copies of these forms are available in the business office.

Effective Date of Notice of Privacy Practices: March 5, 2013
Revision Date of Notice of Privacy Practices: September 20, 2013

David Volosov
David Volosov, President

March 11, 2016
Date

NOTICE OF PRIVACY PRACTICES

Record of Acknowledgements

Name of Service Recipient:_____ Date:_____

We are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information. We are required by state and federal regulations to abide by the privacy practices described in the notice provided to you including any future revisions that we may make to the notice as may become necessary or as authorized by law.

Effective Date and Changes or Revisions to the Privacy Notice

The effective date of the Notice of Privacy Practices is March 5, 2003.

We reserve the right to change our facility's *Privacy Notice* at any time and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future about you. Should we revise or change our *Privacy Notice*, we will post a copy of the new or revised notice in our main lobby. You may obtain a copy of the new/revised *Privacy Notice* from the business office or download a copy from our website (as applicable).

The Notice of Privacy Practices was revised on September 20, 2013.

Privacy Notices, Information Restrictions, Record Amendments/Corrections, Disclosures of Information, Revoking an Authorization, Inspection and Copying of Records, Confidential Communications, Filing Complaints, Etc.

Should you have any questions concerning our Company's privacy practices, obtaining copies of our privacy notice, requesting restrictions on the release of your information, revoking an authorization, amending or correcting your health information, obtaining a listing of the information we disclosed concerning your health information, requests to inspect or copy your medical information, requests that we communicate information about your health matters in a certain way, denial of access to your health information, filing complaints, or any other concerns you may have relative to our Company's privacy practices, please contact:

Kean Quinton, Organizational Privacy Officer
Salisbury Management, Inc
3710 Hempland Road, Suite 1
Mountville, PA 17554
(717) 405-3287 extn: 3715
(717) 285-9015
kquinton@salisburymgt.com

YOU MAY ALSO FILE COMPLAINTS WITH:
Office for Civil Rights
US Department of Health and Human Services
150 S. Independence Mall West, Suite 372, Public Ledger Building
Philadelphia, PA 19106-9111
Phone: (800) 368-1019
Fax: (215) 861-4431
TDD: (800) 537-7697
Email: OCRComplaint@hhs.gov
Website: https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsp

Acknowledgement

I certify that I received a copy of the Notice of Privacy Practices and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the Company is committed to protecting my health information.

Date:_____ My Signature:_____

My Printed Name:_____

Date:_____ Signature of Witness:_____

I certify that I am the authorized representative of _____, and that I have received the Notice of Privacy Practices on behalf of this individual and that the facility provided me with an opportunity to review this document and ask questions to assist me in understanding his/her privacy rights. I am satisfied with the explanations provided to me and I am confident that the facility is committed to protecting health information.

Date:_____ Signature of Representative:_____

Printed Name:_____

Relationship to Individual:_____

Date:_____ Signature of Witness:_____

A copy of this document must be provided to the person who signed the Notice of Privacy Practices Acknowledgement and a copy of the Acknowledgement must be filed in the medical record.