# Notice of Privacy Practices

**This Notice Describes How Medical Information About You May Be Used And Disclosed And How You May Receive Access To This Information.**

**Please Review It Carefully.**

1. Our Commitment To You

Signature Aesthetics LLC is committed to maintaining the privacy of your health information. During your treatment with us, physicians, nurses, and other personnel may collect information about your health history and your current health status. This Notice explains how that information, called “Protected Health Information” may be used and disclosed to others. The terms of this Notice apply to health information produced or obtained by Signature Aesthetics LLC.

1. Our Legal Duties

The HIPAA Privacy Law requires us to provide this Notice to you regarding our privacy practices, our legal duties to protect your private information and your rights concerning health information about you. We are required to follow the privacy practices described in this Notice whenever we use or disclose your protected health information (PHI). Other companies or persons that perform services on our behalf, called Business Associates, must also protect the privacy of your information. Business Associates are not allowed to release your information to anyone else unless specifically permitted by law. There may be other state and federal laws, which provide additional protections related to communicable disease, mental health, substance or alcohol abuse, or other health conditions.

1. Your Health Information May Be Used And Disclosed

The HIPAA Privacy Law permits Signature Aesthetics LLC to make uses and disclosures of your health information for purposes of treatment, payment and health care operations.

* **Treatment:** We will use and may share health information about you for your health care and treatments. For example, a nurse or medical assistant will obtain treatment information about you and record it in a medical record. Alternatively, one of our physicians may use information about you for a consultation with, or a referral to, another physician to diagnose your illness and determine which treatment option, such as surgery or medication, will best address your health needs. Except in emergency circumstances, we will make a “good faith effort” to get your permission prior to making disclosures outside Signature Aesthetics LLC for treatment purposes.
* **Payment:** We may use and disclosehealth information about you to obtain payment for the care and services that we have provided to you. For example, we may need to provide your health plan provider with information about you, your diagnosis, and the treatment provided to you at Signature Aesthetics LLC so that your health insurer will pay us, or reimburse you, for the treatment. We may also contact your health insurance to obtain prior approval about a potential treatment.
* **Health Care Operations:** We may use and share health information about you for Signature Aesthetics LLC’s health care operations, which include planning, management, quality assessment, and improvement activities for the treatments that we deliver. For example, we may use your health information to evaluate the skills of our physicians, nurses, and other health care providers in caring for you. We also may use your information to review quality and health outcomes. We will obtain your written permission before making disclosures to others outside Signature Aesthetics LLC for health care operations purposes.
* **Appointment Reminders:** We may use and disclose PHI to contact you for appointment reminders and to communicate necessary information about your appointment.
* **Health-Related Benefits, Services and Treatment Alternatives:** We may also contact you about new or alternative treatments or other health care services.  For example, we may offer to mail to you newsletters, coupons, or announcements.
* **As Required by Law:** We must disclose health information about you if federal, state, or local law requires us.
* **Serious Threat to Health or Safety:** Consistent with applicable laws, we may disclose your PHI if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
* **Public Health Risks:** As authorized by law, we may disclose health information about you to public health or legal authorities whose official responsibilities generally include the following:
* To prevent or control disease, injury or disability;
* To report child abuse or neglect;
* To report reactions to medications or problems with products;
* To notify people of recalls of products they may be using;
* To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
* To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
* **Specialized Government Functions:** If you are a member of the military or a veteran, we will disclose health information about you as required by command authorities; or if you give us your written permission. We may also disclose your health information for other specialized government functions such as national security or intelligence activities.
* **Health Oversight Activities:** Wemust disclose health information to a health oversight agency for activities that are required by federal, state or local law. Oversight activities include investigations, inspections, industry licensures, and government audits. These activities are necessary to enable government agencies to monitor various health care systems, government programs, and industry compliance with civil rights laws. Most states require that identifying information about you, such as your social security number, be removed from information releases for health oversight purposes, unless you have provided written permission for the disclosure.
* **Required by HIPAA Law:** The Secretary of the Department of Health and Human Services (HHS) may investigate privacy violations. If your health information is requested as part of an investigation, we must share your information with HHS.
1. Situations In Which Your Health Information May Be Disclosed With Your Written Consent

For any purpose other than the ones described above, we may only use or share your health information when you give us your written authorization to do so. For example, you will need to sign an authorization form before we can send your health information to your life insurance company. You may revoke an authorization at any time.

* **Marketing:** We must also obtain your written authorization before using your health information to send you any marketing materials. The only exceptions to this requirement are that:
	+ We can provide you with marketing materials in a face-to-face encounter or a promotional gift of very small value, if we so choose
	+ We may communicate with you about products or services relating to your treatment, to coordinate or manage your care, or provide you with information about different treatments, providers or care settings.
1. Your Rights Regarding Health Information We Maintain About You
* **Right to Inspect and Copy**: You have the right to inspect and receive a copy of your PHI. A request to inspect your records may be made to your nurse, doctor or to the Medical Records Department. For copies of your PHI, requests must go to the Medical Records Department. For PHI in a designated record set that is maintained in an electronic format, you can request an electronic copy of such information. There may be a charge for copies of your PHI.
* **Right to Request Amendment:** If you believe that any health information we have about you is incorrect or incomplete, you have the right to ask us to change the information, for as long as Signature Aesthetics LLC maintains the information. To request an amendment to your health information, your request must be in writing, signed, and submitted to Signature Aesthetics LLC. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be maintained with your records. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
* **Right to Request Restrictions on Use and Disclosure:** You have the right to request a restriction or limitation on certain uses and disclosures of your health information.

To request restrictions, you must make your request in writing to Signature Aesthetics LLC. In your request, you must tell us:

* What information you wish to limit
* Whether you wish to limit our use, disclosure, or both
* To whom you want the limits to apply – for example, if you want to prohibit disclosures for insurance payment, health care operations, for disaster relief purposes, to persons involved in your care, or to your spouse.

You or your personal representative must sign it.

*We are not required to agree to your request****,*** but we will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction.

* **Right to an Accounting of Disclosures:** With some exceptions, you have the right to receive an accounting of certain disclosures of your PHI. Your accounting request must be in writing and signed by you or your personal representative and submitted to Signature Aesthetics LLC. Your request must specify the time in which the disclosures were made. These disclosures may not go back further than six years from the date of the request. [You may receive one free accounting in any 12-month period. We will charge you for additional requests.]
* **Right to Request Alternate Communications:** You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box. *You must submit your request in writing to Signature Aesthetics LLC.* We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.
* **Right to Receive a Copy of this Notice:** You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time.
* **Right to Cancel Authorization to Use or Disclose:** Other uses and disclosures of your health information not covered by this Notice or the laws that govern us will be made only with your written authorization. You have the right to revoke your authorization in writing at any time, and we will discontinue future uses and disclosures of your health information for the reasons covered by your authorization. We are unable to take back any disclosures that were already made with your authorization, and we are required to retain the records of the care that we provided to you.

**For further information:** If you have questions, or would like additional information, you may contact Nancy Andrewsat **nancy@signatureaesthetics.com**.

**To File a Complaint:** You may submit any complaints with respect to violations of your privacy rights to Signature Aesthetics LLC. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services if you feel that your rights have been violated. There will be no retaliation from Signature Aesthetics LLC for making a complaint.

**Changes to this Notice:** If we make a material change to this Notice, we will provide a revised Notice available at our reception desk or on our website www.signatureaesthetics.com.

**Contact Information:** Unless otherwise specified, to exercise any of the rights described in this Notice, for more information, or to file a complaint, please contact Nancy Andrews, nancy@signatureaesthetics.com.

**Effective Date:** This Notice is effective as of October 13, 2020.