



Notice of Patient Rights and Privacy Practices

This notice is to inform all patients and their legal representatives of their patient right and responsibilities upon the beginning of treatment. Each patient will receive a written copy of this notice. Please review it carefully and sign the acknowledgment below.

Patient's Confidential Information

'Ike Loa Therapeutic Services ('Ike Loa) is dedicated to protecting sensitive patient information from being disclosed. We will ensure that all confidential information that identifies the patient or their family is stored in a secured and private location. All electronic databases are HIPAA compliant. 'Ike Loa will provide patients and/or parents/guardians this notice of legal duties and privacy practices with respect to confidential information about patient and/or family members. We adhere to the terms of this notice.

How Confidential Information Used or Disclosed

- For Treatment. We may use confidential information with other 'Ike Loa colleagues in order to provide quality services.
- For Payment. We may use and disclose confidential information about a patient so that services provided may be billed and collected. We may need to disclose confidential information about a patient in order to obtain prior approval service authorization from health plans.
- Appointment Reminders. We may use and disclose confidential information to contact patients or family members as a reminder that you have an appointment for treatment or confidential care.
- Alternatives: We may use and disclose confidential information to family members about recommended possible options or alternatives that may be important to you.
- Service Related Benefits: We may use and disclose confidential information about patients or family members to an entity assisting in a disaster relief effort (e.g., Red Cross or other emergency relief personnel) so that the parent/legal guardian or family members can be notified about patient's location, condition, and status.
- As Required by Law: We will disclose confidential information about patients and family members when required to do so by federal, state, or local law. Such as in cases of suspected abuse, threats of suicide, threats of homicide, or medical emergencies.
- Public Health Risks: We may disclose confidential information about patients for public health activities. These activities generally include the following: to prevent or control disease, injury, or disability, to report a death, to report reactions to medications or other sentinel events, and to notify a person who may have been exposed to a disease or may be at risk for contracted or spreading a disease or condition.
- Control Oversight Activities: We may disclose confidential information to a contracted State Department Contracts staff for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights law and contract standards.
- Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose confidential information about patients in response to a court or administrative order or allegations of fraud or abuse. We may also disclose confidential information about patients in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

- Law Enforcement: We may release confidential information if asked to do so by a law enforcement official, in response to a court order, subpoena, warrant, summons or similar process for the following:
 - to identify or locate a suspect, fugitive, material witness, or missing person about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
 - about a death we believe may be the result of criminal conduct; ○ about criminal conduct at the office; and
 - in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.
- National Security and Intelligence Activities: We may release confidential information about patients and family members to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- Protective Services for the Patient and Others: We may disclose confidential information about patients and family members to authorized federal officials so they may provide protection to the patient, other authorized persons or foreign heads of state or conduct special investigations.
- Other Uses of Confidential Information: Other uses and disclosures of confidential information not covered by this notice or the law that apply to us will be made only with the patient or parent/legal guardian's written permission. If the patient or parent/legal guardian gave us written permission to use or disclose confidential information about a patient, the patient or parent/legal guardian may revoke that permission in writing, at any time. *If permission is revoked, we will no longer use or disclose confidential information about the patient for the reasons covered by the written authorization of the patient or parent/legal guardian.* The patient or parent/legal guardian understands that we are unable to take back any disclosures we have already made with their permission, and that 'Ike Loa Therapeutic Services is required to retain records of the service provided for seven years after the end of services or after the patient reaches the age of majority.

Patient Rights Regarding Confidential Information

Patients have the following rights regarding confidential information.

- Right to Inspect and Copy: The patient or parent/legal guardian has the right to inspect and receive a copy of confidential information that may be used to make decisions about patient services. Usually, this includes confidential information such as billing records and documented services provide but may not include therapy notes (therapy notes are progress notes made about a therapy session which are kept separate from the rest of the medical record). Copying is done at the expense of the patient or parent/legal guardian to cover the cost of materials and time expended. To inspect or get photocopies of your confidential information, submit a written request, 2 weeks in advance, to the following address or email address:
 - 2176 Lauwiliwili Street, Kapolei, HI 96707
 - admin@ike-loa.com
- Right to Amend: If the patient or parent/legal guardian feels that the confidential information we have about the patient or family member is incorrect or incomplete, the patient or parent/legal guardian may ask us to amend the information. The patient or parent/legal guardian has the right to request an amendment for as long as the information is kept by ILTS. To request an amendment, the request must be made in writing by the patient or parent/legal guardian and submitted to the agency. In addition, the patient or parent/legal guardian must provide a reason to support this request. In addition, the agency may deny the request if the patient or parent/legal guardian ask to amend information that: 1) was not created by the agency, unless the person or entity that created the information is no longer available to make the amendment; 2) is not part of the confidential information kept by the agency; 3) is not part of the information which the patient or parent/legal guardian would be permitted to inspect and copy; or 4) is accurate and complete.
- Right to Request Restrictions: The patient or parent/legal guardian has the right to request a restriction or limitation on the confidential information the agency uses or discloses about the patient's services and progress, payment or quality improvement of operations. The patient or parent/legal guardian also

has the right to request a limit on the confidential information disclosed about the patient to someone who is involved in services. We are not required to agree to your request. To request restrictions, the patient or parent/legal guardian must inform an 'Ike Loa personnel or 'Ike Loa therapist: 1) what information is to be limited; 2) whether the patient or parent/legal guardian want to limit our use, disclosure, or both; 3) to whom they want the limits to apply (e.g., disclosures to a spouse); and 4) limitations as to how the information is transmitted such as fax or secured email.

- Right to a Paper Copy of this Notice: The patient or parent/legal guardian has a right to a paper copy of this notice. They may ask for an additional copy of this notice at any time.

Notice of Patient Rights

<ul style="list-style-type: none"> • The right to be treated with respect and privacy. • The right to treatment no matter what your situation is. • The right to know about the services you can receive, the provider, and to know what your treatment and service choices are. • The right to know all you rights and responsibilities. • The rights to get help understanding your services. • The right to use your rights freely and not be treated differently by doing so. • The right to receive information and services in a timely way. • The right to be a part of all choices about your treatment and have your treatment plan in writing. 	<ul style="list-style-type: none"> • The right to disagree and ask for changes in your treatment plan. • The right to seek a different provider. • The right to refuse participation in treatment. • The right to be free from unlawful discrimination. • The right to look at your records, add your opinion when you disagree, receive a copy of your records, and the right to confidentiality of treatment records. • The right to file a complaint and to be able to do so without fear of retaliation. • The right from being restrained or secluded unless an allowed doctor or psychologist approves.
--	--

Patient Responsibilities and Involvement in Care

<ul style="list-style-type: none"> • A responsibility to actively participate in decisions regarding your health care. • A responsibility to be as accurate and complete as possible when asked for information about your medical history. • A responsibility to be honest and direct about everything that happens to you as a patient. • A responsibility to let your provider know if you are concerned about a treatment, or if you feel you cannot or will not follow a specific treatment plan. • A responsibility to accept the outcome if your treatment plan is not followed. 	<ul style="list-style-type: none"> • A responsibility to notify your provider at once if you notice or you think you notice, any perceived risks in your care or unexpected changes in your condition. • A responsibility to ask promptly for clarification if you do not understand what is asked of you, or why it is asked. • A responsibility to be considerate and respectful of other patients. • A responsibility to follow the agency rules and regulations. • A responsibility to examine and pay your bill and to ask any questions you have regarding the charges or method of payment.
--	---

Acknowledgement:

- I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.
- I have been informed that I may review this practice’s Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.
- I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.
- I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).
- I understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.
- I also understand that I have a right to a paper copy of this practice’s Notice of Privacy Practices and Patient rights. I may ask for it at any time.

Please initial below:

_____ I acknowledge that I have been provided a copy of this practice’s Notice of Patient Rights and Privacy Practices.
_____ I acknowledge that I do understand the Notice of Patient Rights and Privacy Practices.

I have read this consent and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and health care operations.

Printed Name of Patient: _____

Signature: _____ Date: _____
(Patient/parent or legal guardian)

If signed by patient representative, print name and relationship to patient: _____