SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding our office's complete Notice of Privacy Practices

Our complete Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to our complete Notice of Privacy Practices for the person or persons whom you may contact.

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110 East 39th Street
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(402) 412-3338

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ACKNOWLEDGEMENT OF RECEIPT
of
Notice of Privacy Practices

We are required by law to maintain the privacy of your medical records. By signing below, I acknowledge that I was given a copy of the Notice of Privacy Practices

_____ _____

Patient Name (PLEASE PRINT) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

COMMUNICATION

If we must call you about your appointment, treatment, or bill, I authorize you to: (check all that apply)

___ Speak to any family member

___ Speak only to _____

___ Leave a message at work

___ Leave message on answering machine

___ Do not leave message