Hearing Health Care Services

1515 W NC Highway 54
Suite 100
Durham, NC 27707
(919) 489-0995

Department of Health and Human Services Privacy Rule under HIPAA (Health Insurance Portability and Accountability Act)

In compliance with the September 23, 2013 Omnibus Rule

This **Notice of Privacy** describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your Healthcare Provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to process your health care bills, to support the operation of the Healthcare Provider’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or mange your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a Healthcare Provider to whom you have been referred or whom referred to, ensure that the Healthcare Provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for hearing aids, or hearing testing may require that your relevant protected health information be disclosed to the health care plan to obtain approval for such services.

Healthcare Operations:
We respect, secure, and protect the privacy of our patients’ personal health information. When appropriate and necessary, we provide the **minimum necessary** to only those healthcare professionals in need of your health care information and treatment. We have indirect treatment relationships with hearing aid and earmold companies, and disclose personal information for purposes of payment, or health care products.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: Public Health issues as required by law; Communicable diseases; Health Oversight; Food and Drug Administration requirements; Legal Proceedings; Military Activity and National Security; Workers’ Compensation; Hearing Aid Manufacturers.

Other Permitted and Required Uses and Disclosures: Other disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

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Your Privacy Rights

Following is a statement of your rights with respect to your protected health information.

I. You have the right to inspect and request copies of your protected health information.
We support your full access to your personal medical records. You may request transmission of your medical records to a designated party in any form, hard copy or electronically. In such cases, we will verify the identity of the individual making the request and take reasonable steps to ensure that the email address of the recipient is correct. However, under federal law, you may not inspect nor copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

II. You have the right to request a restriction of your protected health information.

- This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this **Notice of Privacy Practices**. Your request must state the specific restriction requested and to whom you want the restriction to apply.
- **Our Healthcare Providers are not required to agree to a restriction that you may request. If your Healthcare Provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Provider.**
- It is your right to opt out of the use of your personal health information for marketing purposes by Hearing Health Care Services, Inc. or its suppliers (Hearing Aid Manufacturers)

III. You may request transmission of your medical records to a designated party in any form, hard copy or electronically. In such cases, we will verify the identity of the individual making the request and take reasonable steps to ensure that the email address of the recipient is correct.
Upon request, you have the right to obtain a paper copy of this notice from us, even if you have agreed to accept this notice alternatively (i.e. electronically).
You may have the right to have your Healthcare Provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

IV. Complaints
You may complain to our Practice Manager or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. **We will not retaliate against you for filing a complaint.** We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (919) 489-0995. You may refuse to consent to the use or disclosure of your personal health information. Under this law, we have the right to refuse treatment should you choose not to disclose your personal health information.

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Financial Policy

Thank you for choosing Hearing Health Care Services PLLC. Our primary mission is to deliver the best and most comprehensive hearing care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, Discover Card, Amex, ApplePay
- Financing through Allegro Credit (12 months no interest, 24-48 months traditional financing)
- Allegro Leasing programs available for many hearing aids and equipment purchases
- Financing Options using the Care Credit healthcare credit card

Please note:

Hearing Health Care Services PLLC (HHCS) requires payment at the time of your visit for any services provided, with the exception of services covered by your plan with which we are in-network. In-network services must be predetermined. Complete insurance information must be provided prior to your visit for insurance to be filed. Some services may be covered by an established care plan and therefore have no additional associated cost. Copays are due at the time of service. Unfortunately best practice care is often not covered by insurance plans, and out-of-pocket charges will be incurred. Any non-covered services will be reviewed prior to providing the service.

For patients with insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your hearing aids. For Medicare recipients, a referral from the patient's Primary Care Physician is necessary for Medicare to cover the cost of medically necessary hearing tests. Medicare categorically excludes all non-surgical hearing management, therefore does not pay for hearing aids, any hearing aid services, or auditory rehabilitation services.

For any equipment purchases, a down payment of 50% will be required at the time of the order. Payment in full is expected at the time of fitting unless insurance reimbursement is anticipated and verified prior to the date of the fitting. Prior authorization and verification of benefits from insurance companies are not binding, nor are they a guarantee of payment. Patients should be prepared to cover the full cost of services and equipment provided, or any balance remaining after insurance reimbursement.

Insurance benefits must be reviewed and verified by HHCS staff prior to the fitting to avoid payment in full at that time. This process can take 2-3 business days. Alternatively, equipment can be paid for in full and filed for reimbursement directly to the patient. We are happy to complete the filing on your behalf if provided with all necessary information.

In the event of overpayment refunds will be processed within 10 business days of receipt of the reimbursement.

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Hearing Health Care Services, PLLC charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the hearing care you want and need.

Responsibility for payment of Medical Services: Medical claims will be filed with my insurance carrier as a courtesy. However, should my insurance deny for any reason such as; an authorization, deductible, or non-covered service, I understand that I will be responsible for my bill. I agree that I will make full payment to HHCS at the time of the receipt of invoice for services rendered. I agree that I am financially and legally responsible for all charges incurred, regardless of insurance coverage. In the event that I do not pay all of the charges due to HHCS, I will pay HHCS's reasonable attorney's fees spent in any collection effort against me and pay interest at a rate of one and one-half percent (1.5%) per month on any unpaid balance.

Patient or Responsible Party Signature **Date**

Patient Name or Responsible Party (Please Print)