HIPPA

NOTICE OF PRIVACY PRACTICES FOR KINGSWAY ARMS NURSING CENTER, INC.

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION,
PLEASE REVIEW IT CAREFULLY.

Kingsway is required by law to maintain the privacy of your health information and to provide you with notice of Kingsway's legal duties and privacy practices with respect to your health information. Kingsway is required to abide by the terms set forth in this notice. We reserve the right to change this notice and to make the changed notice effective for medical information we already have about you as well as any information we receive in the future. We will provide a revised copy of this notice to you upon your request.

1. HOW KINGSWAY MAY USE & DISCLOSE YOUR MEDICAL DEFORMATION

Kingsway may use your health information for the purposes of providing medical treatment, obtaining payment for services rendered, and/or administering health care operations, as well as for the purposes set forth in this notice or otherwise as authorized or required by law. Kingsway will restrict access to your health information to persons who are directly involved in those functions. All other uses and disclosures of your health information will not be made without your authorization, which you may revoke by providing Kingsway with a written notice. Some examples of how Kingsway may use and disclose your health information are:

A. Uses and Disclosures for treatment: For example, nurses, nurse's aides, physicians, medical staff, social workers, therapists, pharmacists or other medical practitioners who are directly involved in your treatment, must and shall be allowed access to your health information as well as be permitted to share it with another nurse, nurses' aide, physician, medical staff, social worker, therapist, pharmacist or other medical practitioner, a medical director or Kingsway personnel who participates in your treatment. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

B. Uses and Disclosures for Payment: For example, we may give your health plan, or other payor, your medical information in order to identify the treatment, bill for services or receive payment. We also may disclose your health information to another covered entity or a health care provider for their payment activities.

C. Uses and Disclosures for Health Care Operations: These types of uses and disclosures of your health information are necessary to run the assisted living adult home and nursing home facilities and make sure that all of our Patients or Residents receive quality services. For example, we may use medical information about you to review our treatment procedures and to evaluate the performance of our staff. We may also disclose your health information to another health care provider for its health care operations, provided they have or had a direct relationship in your care, and to government regulators.

D. Other Permitted Uses and Disclosures: Kingsway may make disclosures to the Department of Health, in response to subpoenas or as otherwise required or permitted by law or regulation. Kingsway also may use or disclose your health information provided you have an opportunity to agree, prohibit or restrict the use or disclosure, to a family member, other relative, a close personal friend, or anyone identified by you, who is involved in your medical care or payment for your care. If you do not have the opportunity to agree or object to such use or disclosure because you are not present or because of your incapacity or emergency circumstances, Kingsway may, in the exercise of professional judgment and its experiences with common practice, determine whether the disclosure is in your best interest and if so disclose health information that is directly relevant to that person's involvement with your care.

II. YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

A. Your Right to Inspect and Cone: You have the right to inspect and copy your health information that may be used to make decisions about your care. If you are a parent or legal guardian of a Patient or Resident; you may also obtain a copy of the health care information of your non-emancipated child(ren) except where prohibited by law for specific health care services.

Requests for copies of your health information must be made in writing to Kingsway's Administrative Offices at the address in paragraph Z"H" of this Notice. Such requests must be made on Kingsway's "medical Authorization" release form, which may be obtained from the Administrative Offices. Requests must include the notarized signature of the Patient or Resident's parent or legal guardian in the event that the Patient or Resident is a non-emancipated minor.

We may deny your request to inspect and copy in limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person

B. Your Right to Request Amendments: If you feel that medical information about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Kingsway. To request an amendment, your request must be made in writing and submitted to the Administrative Office. You must provide a reason that supports your request.

We may deny your request for an amendment if it s\is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (a) was not treated by Kingsway, unless the person or entity that created the information is no longer available to make the amendment; (b) is not part of the medical permitted to inspect and copy; or (c) is accurate and complete.

C. Your right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to the Administrative Offices. Such requests must include the information you want to limit: whether you want to limit our use; disclosure, or both; and the person(s) to whom you want these limits to apply (e.g., disclosures to your family).

D. Your Right to Request Confidential Communications: You have the right to request that we communicate with you regarding medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Administrative Offices. We will accommodate all reasonable requests. Your request must specify how and where you wish to be contacted.

E. Your Right to an Accounting of Disclosures: You have the right to request a list of the disclosures we made of your health information for purposes other than treatment, payment of health care operations, or a permitted or required by law or regulation. To request a list of disclosures, you must submit your request in writing to the Administrative Offices. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list. The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list. 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.

F. Your Right to a Paper Copy of the Notice: You may ask us to give you a copy of this notice at any time. Even if you agree to receive this notice in electronic form, you may receive a paper copy upon request. You may also obtain a copy of this notice at our website, www.kingswaycommunity.com. To obtain a paper copy of this notice, you must submit your request in writing to Kingsway's Administrative Office.

G. <u>Complaints</u>: If you believe your privacy rights have been violated, you have the right to file a complaint with Kingsway and with the Secretary of Health and Human Services. To file a complaint with Kingsway, send it in writing to the Administrative Offices. You will not be penalized or discriminated against for filing a complaint.

H. <u>Designated Privacy Administrator</u>: The Designated Privacy Administrator for Kingsway Arms Nursing Center, Inc. is the Administrator. Requests for further information should be addressed to the Administrator and may be reached at Kingsway's Administrative Offices at 323 Kings Road, Schenectady, New York 12304. The Designated HIPPA Security Officer for Kingsway Arms Nursing Center, Inc is the Director of Information Services. He may be reached at Kingsway's Administrative Offices at 323 Kings Road, Schenectady, New York 12304. Please submit all other requests in writing to Kingsway's Administrative Offices at 323 Kings Road, Schenectady, New York 12304.

I, _____, acknowledge that on this ____day of _____20__ I received and read the above **Notice of Privacy Practices at Kingsway Arms Nursing Center, Inc.** and I agree with its requirements.

_____
(signature)

Signature on File, Assignment of Benefits, Financial Agreement

_____ _____
Beneficiary Name (Print) Medicare Number

1. **Medicare**: I request that payment of authorized Medicare benefits be made on my behalf to ***On-Sight Vision Services*** for services furnished me by ***On-Sight Vision Services.*** I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes releases of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. ***On-sight Vision Services*** accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MediGap**
I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to ***On-Sight Vision Services***, if possible
or otherwise to me.

3. **Release of information**: ***On-Sight Vision Services*** may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to ***On-Sight Vision Services*** for reimbursement for services rendered, and (2) any health care
provider for continued patient care. ***On-Sight Vision Services*** may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **Other insurance**: I understand that ***On-Sight Vision Services*** maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that ***On-Sight Vision Services*** has no contract expressed or implied, with any plan that does not appear on the list.
The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by ***On-Sight Vision Services*** if I belong to a plan that dopes not appear on the above mentioned list.

5. **Non-covered services:** I understand that ***On-Sight Vision Services*** cntracts with
health care service plans (i.e. HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Exam;les of non-covered services include, but are not limited to services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with ***On-Sight Vision Services*** to obtain necessary health care service plan authorizations.

6. **Financial agreement:** I agree that in return for the services provided to the patient by ***On-Sight Vision Services,*** I will pay my account at the time service is rendered or will make financial arrangements satisfactory to ***On-Sight Vision Services*** for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to ***On-Sight Vision Services.*** If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to ***On-Sight Vision Services.*** However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____ _____

Beneficiary Signature or Authorized Party **Date**