American Arthritis and Osteoporosis Care Center

Practice Privacy Statement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOUR CAN GET ACCESS TO THIS INFORMATION:

I. **This is a formal notification, as required by CMS (Centers for Medicare and Medicaid Services) concerning the privacy policy of this practice.** It is important that all patients and staff understand the importance of guarding patient information.

II. This practice has a legal obligation to maintain all medical records and information in the strictest of confidence as required by law. What this means to the patient is that we must safeguard patient information. This means we cannot release information to others without your written consent, including conversations, reminder calls, test results and other information that may be of a confidential nature. Patient information about health care is identified as "PHI" or protected health information.

This change in policy requires that you, the patient, identify and clarify at the time of registration or re-registration with this practice who we can talk to, how we can leave information on your behalf, and the process for ongoing continuity of your medical care. You can change this information at any time with either written notification or verbal notification, followed up in writing. Changes can only impact the care or information from that point in time forward.

III. Your protected health information (PHI) is an intricate part of your medical care, and can be used or disclosed with your written consent as follows:

- For your treatment in this practice and other locations under the physicians immediate care. This may include any referral for services such as lab, x-rays, other diagnostic testing or treatment related to your condition or medical care needs. This may also include conversations with other physicians.
- For obtaining payment for treatment with your identified insurance or health coverage program. This would include any documentation related to this process, which may include history forms, progress notes or operative notes. This would include eligibility verification, prior authorization and claim submission.
- For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state laws and regulations.
- Appointment reminders and health related benefit services only with your consent identified on the registration form
- Disclosure to your family and friends concerning any related health care information with your on the registration form which can be modified at any time orally, followed by written consent.
- Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician or medical entity required immediate and full information for care on your behalf.

Certain disclosures can be made without your consent, and they are as follows:

- Disclosure required by the government or law enforcement agencies. Specific areas that require release include gun shot wounds, domestic violence, and victims of abuse or neglect.
- Information used for public health purposes, medical examiners or related to a person's death or for the health department for disease tracking.
- Information used for health care oversight, such as a site review by an insurance program.
- Information related to organ donation.
- Information related to certain research procedures, the majority of this information is stripped of any personal data, and is normally generic (age, sex, diagnosis) in nature.
- Information provided to avoid harm if there is a threat to patient or other safety.
- Specific governmental functions.
- Workers compensation review.

IV. Your rights with respect to you protected health information.

- The right to request limits on the uses and disclosure at registration or any time during your care.
- The right to choose how we send this information to you, including an alternate address.
- The right to see and obtain copies of this information, but there may be copy and postage fees..
- The right to get a listing of who we have made disclosures to about your PHI.
- The right to correct and update your file through an amendment process if appropriate.

V. This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.

VI.If you have a concern or complaint about how your protected health information is being used, from this time forward you should first contact our office to see if we can resolve your concerns or you may contact the Office of Civil Rights or the Ohio Medicare Carrier, GBA Palmetto.

- Contact the office manager and complete a complaint form for review and discussion.
- If you are not satisfied with this response, you may report the practice to:

Office of Civil Rights
Regional Manager
Department of Health & Human Services
233 N. Michigan Avenue, Suite 240
Chicago, Illinois 60601
(312) 886-1807

Or:

GBA Palmetto
Part B Operations - HIPAA Compliance Concern
PO Box 182957
Columbus, Ohio 43218

*Patient signature on receipt of Privacy Notice;_____ Date:_____
Patient unable to sign due to:_____ Date:_____
Patient refused to sign - witness:_____ Date:_____

439 East Wilson Bridge Road
Worthington, OH 43085
Ph: 614-781-1749 Fax: 614-781-1751

American Arthritis and Osteoporosis Care Center

Privacy Consent - For the Use and Disclosure of Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to American Arthritis and Osteoporosis Care Center to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize (this practice), and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professional for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

Consent related to the Privacy Notice: I have had a chance to review and Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take affect until the practice receives it.

*Patient/Guardian: _____ Date: _____
Name printed: _____ If not patient, relationship: _____

Copy of Practice Privacy statement signed or initiated with patient/guardian on: _____
Patient unable to sign privacy statement due to: _____

Revocation:
I hereby revoke the consent given above:
Patient/Guardian: _____ Date: _____

Name printed: _____ If not patient, relationship: _____

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

*Patient/Guardian initial: _____ Date: _____

439 East Wilson Bridge Road
Worthington, OH 43085
Ph: 614-781-1749 Fax: 614-781-1751