

Notice of HIPPA Medical Records Privacy and Casscells Orthopaedics Policy and Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, AS WELL AS YOUR RIGHTS AND RESPONSIBILITIES AS A PATIENT OF CASSCELLS ORTHOPAEDICS. PLEASE REVIEW IT CAREFULLY.

The Medical Record generated by this office is the property of Casscells Orthopaedics and will be kept private to the full extent of the law. By law, medical information must be provided to anyone with a properly executed subpoena. Medical information must be provided by law to third party payers including Center for Medicare and Medicaid Services (CMS). If the patient engages in personal injury litigation, by law, they forfeit any right to privacy of their medical records. Except for these circumstances, Casscells Orthopaedics will take great care to protect your privacy. Unless required by law, medical records will not be released until specifically authorized by the patient. The patient may request a reproduction of their own Medical Record for a modest prepaid fee. Legal disputes between the medical practice and the patient or his/her representation must be settled by arbitration, or the patient will bear the full cost of litigation for both parties, including but not limited to the standard reimbursement hourly rate for the physician's time preparing and testifying in deposition, regardless of outcome. Certain medical services may not be reimbursed by the payer despite being medically necessary in the judgment of the doctor and these determinations may be made long after the decision to provide the service. It is understood that these services will be billed directly to the patient in the event that the carrier denies payment and that reimbursement for these costs are an issue solely between the patient and his/her insurance carrier or CMS, and that the patient, as recipient of the services is ultimately responsible for the bill. It is understood that the delivery of health care is a service that must be purchased, not unlike any other service, and generates a valid fee for service which is a debt owed by the patient. This Notice of Privacy Practices, patient rights and responsibilities describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required 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, including information related to sexually transmitted diseases and HIV.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, 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 pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of you health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician 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 a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security, Workers' Compensations, Inmates, Required Uses and Disclosures, Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of section 164.500.

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

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You're Rights

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

You have the right to inspect and copy your Protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; 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 prohibits access to protected health information.

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 to be disclosed to family members or friends who may be involved in your case 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.

Your physician is not required to agree to a restriction that you may request. If your physician 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 Professional.

You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agrees to accept this notice alternatively, example: electronically.

You may have the right to have your physician 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.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

The patient acknowledges that many factors influence the outcome of medical treatment including the morphology, habits and behavior of the patient and the patient ultimately is at least equally responsible for any and all outcomes. The patient forfeits his/her right to privacy of the medial record in the event of disclosure to the press or the media of any kind of confidential doctor patient information by the patient or any person representing the patient and the patient assumes full responsibility for the deleterious effect this may have on the reputations of the physicians and the practice. Both parties aggress that the relationship between a patient and a physician is private and privileged and its sanctity shall not be violated except as mandated by law. 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 protect health information.

4/03

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice. This notice includes the following healthcare providers for services rendered at Casscells Orthopaedics & Sports Medicine, P.A.

- Christopher D. Casscells, M. D.
- David K. Solacoff, M.D.
- ABC for Doctors-Billing Department

I, _____ have read and understand the following and all
Print Name of my questions have been answered.

Patient Signature

Date

Witness

Date

Persons Authorized to Receive Protected Health Information:

Name of person/relationship/organization

Name of person/relationship/organization

Name of person/relationship/organization

Use and disclosure of Information (please check below):

I authorize the person(s) listed above to receive all health/billing information about appointments, treatment and/or information pertinent to my healthcare and/or payment for my healthcare provided at Casscells Orthopaedics & Sports Medicine, P.A.

I do not authorize the following information to be disclosed to any other parties except to me as the patient and my Primary Care Physician.

This authorization is effective unless revoked or terminated in writing by the patient or patient's personal representative.