

Notice of Privacy Practices
Great Lakes Orthopaedics
6255 Inkster Road
Suite 103
Garden City, MI 48135
734-422-8400

*THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE READ IT CAREFULLY*

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, health care operations and when required by law enforcement.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this is a doctor referring you to another specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a service.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information. We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI.

In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

Person Involved in Care: We may use or disclose health information to notify , or assist in the notification of (including identifying or locating) a family member, your personal representative of another person responsible for your care, of location, your general condition , or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up samples, prescriptions ,medical supplies and other similar forms of health information.

Public Health: We may release information regarding your healthcare to the authorities if we have reason to believe you are a victim of abuse, neglect or other crimes. This disclosure will be to the extent necessary to avert serious threat to your health or safety or the safety of others.

Military: If you are in the Armed Forces, we may disclose information regarding your care to the authorities in the Military. If requested by federal officials, we may disclose your healthcare information in order to maintain national security .Our practice will also disclose to law enforcement officials, information about inmates who are in a correctional facility or in the custody of any law enforcement officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, or letters, or postcards.

Patient Rights: You have the right to inspect and copy your file with limited restrictions. If so, you must request in writing. There is a fee for the photocopies and staff time. Our policy requires you to pick up the copies. Our practice may deny your request to inspect/copy in certain limited circumstances.

Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your personal healthcare information for treatment, payment or health care operations. In addition, you have the right to request that we restrict our disclosure of your information to only certain individuals involved in your care or for the payment for your care, such as family and friends. We are not required to agree to your request. If we do agree, we are bound by the agreement except when required by law, in emergency situations or when the information is necessary to treat you. If you would like to request a restriction, you must make your request in writing to the office contact listed on the bottom of this notice. Your request must be specific in nature and describe the information which is restricted as well as the limits that would apply.

Amendment: You may request an amendment to your healthcare information if you believe it to be incorrect or incomplete. To do so, you must submit in writing a reason which supports your request. We may deny your request for an amendment if it 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 created by us; (b)is not part of the medical information kept by this office; (c) is not part of the information which you would be permitted to inspect and copy; or (d)is accurate and complete.

Payment out of pocket and paid in full: If you have paid for services "out of pocket," in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of September 20, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have the right to express complaints to the practice by contacting the Privacy Officer and or the Secretary of Health and Human Services

Privacy Officer
Kelly Buckley

Name: _____
DOB: _____
Chart: _____
Age: _____
Date: _____

Receipt of Notice of Privacy Practices Written Acknowledgment Form

Great Lakes Orthopaedics
6255 Inkster Road
Suite 103
Garden City, MI 48135
734-422-8400

Notice and Acknowledgment

I acknowledge receipt of Great Lakes Orthopaedic's Notice of Privacy Practices.

Patient or Personal Representative Signature

Date

If Personal Representative Signature appear above, please describe your relationship to the patient.

Good Faith Efforts

The patient presented for treatment on the date below and was provided a copy of the practice's Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgment of receipt of the notice. However, an acknowledgement was not obtained because:

Patient refused to sign

Patient was unable to sign or initial because:

There was a medical emergency (the practice will attempt to obtain acknowledgment at the next available opportunity)

Other: _____

Patient Name

Date