

## **NOTICE OF PRIVACY PRACTICES**

### **TRI-STATE ORTHOPAEDICS & SPORTS MEDICINE and TRI-STATE PHYSICAL THERAPY**

*Effective: April 14, 2003 (Updated: 10/16/2016)*

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

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how our practice, Business Associates and subcontractors may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI, which includes information about you that may identify you or relates to your past, present, or future physical or mental health condition and related healthcare services. *Though some examples are provided within our NPP, not all examples are provided in each category.*

#### ***Uses and Disclosures of Protected Health Information***

Your PHI may be used and/or disclosed by your physician, our office staff and others within and outside of our practice that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice and any other use required by law.

**Treatment:** We will use and disclose your PHI for treatment purposes for our practice to provide, coordinate and manage your healthcare and any related services by healthcare providers within and outside our practice. Some examples of treatment uses/disclosures include:

- During an office visit, physicians, providers, therapists and other staff involved in your care may review your medical record and share/discuss your medical information with each other.
- We may share/discuss your medical information with an outside physician/provider/facility/hospital to whom we have referred/admitted you for care; a physician/provider with whom we are consulting regarding you; or with another healthcare provider, pharmacy or facility who seeks information for the purpose of treating you.
- We may share/discuss your medical information with an outside laboratory, radiology center or other healthcare facility where you have been referred for testing; an outside home health agency, rehab or skilled nursing facility, durable medical equipment agency, pain management or other healthcare provider/facility/company to whom we have referred you for healthcare services and/or products.

**Payment:** Your PHI will be used, as needed, to obtain payment/reimbursement for your healthcare services from other providers, guarantors and health insurance plans/programs. Some examples of payment uses include:

- Sharing information with your health insurer to get paid or to determine whether you are eligible for coverage or whether proposed treatment is a covered service; submitting an itemized bill to your insurer for services provided; or providing supplemental information to your insurer so they can obtain reimbursement from another health plan under a "coordination of benefits" clause in your subscriber agreement.
- Obtaining approval for a hospital stay, surgical procedure, therapy or other service may require that PHI be disclosed to the health plan to obtain approval/authorization.
- Sharing your demographic information (i.e. your address or phone number) with other healthcare providers who seek this information to obtain payment for healthcare services provided to you.
- Mailing you bills/invoice/statements in envelopes with our practice name and return address; or provision of a bill to a family member or other person designated as "responsible" for payment for services rendered to you.
- Providing medical records and other documentation to your health insurer to support the medical necessity of a product or service; or allowing your health insurer access to your medical record a quality review audit.
- Providing information to a collection agency/attorney for purposes of securing payment of a delinquent account or in a legal action for purposes of securing payment of a delinquent account.
- Processing/mailling refunds, emailing or mailing bills/statements, processing credit card or on-line bill payments.

**Healthcare Operations:** We may use or disclose your PHI in order to support the business activities and operations of the practice which may include business planning/development, quality assessment/improvement, medical/peer review, legal services, auditing/compliance functions, patient safety, training of staff/students, resolving patient grievances, licensing/certification/accreditation/credentialing purposes, education, fundraising, and conducting other business management and general administrative activities. We utilize the following business operations, for example:

- We may use a patient sign-in sheet at the front desk, which may be accessible to other patients. We may call patients by name or use their name during their visit in common areas within the office.
- We may contact patients via telephone, mail, email, text, etc. to confirm appointments, leave messages or request a return call. We may communicate with other providers about our patient's care via phone, mail, email or text. We may inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.
- We use paperless systems to document your care including electronic medical records (EMR) and computerized radiology/PACS, we offer online patient portals and utilize features such as e-Rx for electronically transmitting prescriptions to pharmacies and other electronic means that may be shared with providers/facilities within and outside the practice regarding your care, which can be shared via common EMR, email, fax, text or telephone.

**We may use or disclose your PHI 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, for investigations by pharmacies or law enforcement related to misuse of narcotics or prescriptions, coroners, funeral directors, organ donation, research, criminal activity, court order/subpoena, military activity and national security, workers' compensation, inmates, threat to public safety or national security and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your PHI when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

We may disclose your PHI to someone involved in your care or payment for your care, such as a spouse, family member or close friend. For example, if you have surgery we may discuss your physical limitations with the individual assisting in your post-operative care. We assume that any individual accompanying you to the office, hospital or therapy visit is involved in your care. Permitted "incidental disclosures" may occur in the office or hospital. For example other patients may overhear your name as providers coordinate your care. We may share PHI with a "Business Associate" who performs certain functions on behalf of the practice such as a billing software company, collection agency, accounting firm or attorney. We reserve the right to change this notice at any time.

### ***Uses and Disclosures That Require Your Authorization***

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by law. This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. Without your authorization, we are expressly prohibited to use or disclose your PHI for marketing purposes. We may not sell your PHI without your authorization. We may not use or disclose most psychotherapy notes contained in your PHI. We will not use or disclose any of your PHI that contains genetic information that will be used for underwriting purposes. *Examples are provided, but not every use/disclosure will be listed.*

**You may revoke the 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 indication in the authorization.

### ***Your Rights***

The following are statements of your rights with respect to your protected health information. Any requests must be submitted in writing to the Privacy Officer.

**You have the right to inspect and copy your PHI (fees may apply)** — Pursuant to your written request, you have the right to inspect or copy your PHI whether in paper or electronic format. Under federal law, however, you may

not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your PHI** — this means you may ask us, in writing, not to use or disclose any part of your PHI 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 written request must indicate what information you want restricted, how you want it restricted and to whom you want the restriction to apply. If we agree to a reasonable requested restriction, we will abide by it, except in emergency situations when the information is needed for your treatment. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose PHI to your health plan with respect to healthcare for which you have paid in full out of pocket.

**You have the right to request to receive confidential communications** — you have the right to request confidential communication from us by alternative means. You must tell us how you want to be contacted and if it involves an insurance carrier, you must inform us how payment will be handled. We are not required to agree to any unreasonable requests.

**You have the right to request an amendment to your PHI** — this means you may request an amendment of your PHI for as long as we maintain this information. This request must be in writing and accompanied by a reason that supports your request. 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** — you have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

**You have the right to receive notice of a breach** — We will notify you, in writing, if your unsecured protected health information has been breached, and determines through a risk assessment that notification is required.

**You have the right to obtain, and we are required to provide you with, a paper copy of this notice** even if you have agreed to receive the notice electronically. We are required to follow the terms of this notice. We reserve the right to change the terms of this notice at any time. Upon your request, we will provide you with a current Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice is posted at our offices and on our website [www.tristateortho.com](http://www.tristateortho.com)

### **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 Officer of your complaint. **We will not retaliate against you for filing a complaint.**

**If you have any questions regarding this notice or wish to file a complaint, please contact our Privacy Officer/Civil Rights Coordinator at:**

Tri-State Orthopaedics & Sports Medicine, Attention: Privacy Officer/Civil Rights Coordinator  
5900 Corporate Drive, Suite 200, Pittsburgh, PA 15237, (412) 369-4000, Facsimile (412) 369-0150

**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. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our Privacy/Civil Rights Officer.**

## ***Information about nondiscrimination and accessibility requirements***

**Nondiscrimination Statement:** Tri-State Orthopaedics & Sports Medicine and Tri-State Physical Therapy comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. They do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. As appropriate and required, Tri-State Orthopaedics & Sports Medicine, Inc and Tri-State Physical Therapy provides (free of charge):

### **Aids and services to people with disabilities to communicate effectively with us, which may include:**

- Qualified sign language interpreters
- Audio aids or applications
- Written information in other formats (large print, accessible electronic formats, other formats).

### **Language services to people whose primary language is not English, such as:**

- Qualified interpreters
- Audio aids and applications
- Information written in other languages

If you need any of these services, please contact our Privacy/Civil Rights Officer.

If you believe that Tri-State Orthopaedics & Sports Medicine or Tri-State Physical Therapy has failed to reasonably provide these services or discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Privacy/Civil Rights Officer. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance our Privacy/Civil Rights Officer can assist you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Acknowledgement of Receipt of Notice of Privacy Practices**

*Tri-State Orthopaedics & Sports Medicine and Tri-State Physical Therapy*

I received the "Notice of Privacy" for Tri-State Orthopaedics & Sports Medicine and Tri-State Physical Therapy:

_____ <b>Name of Patient</b> (please print)	_____ <b>Date of Birth</b>	_____ <b>SSN (last 4 digits)</b>
_____ <b>Signature of Patient</b> (or patient's Representative)	_____ <b>Today's Date</b>	
_____ <i>Name of Patient's Representative (if applicable)</i>	_____ <i>Relationship to Patient</i>	

**Limited Patient Authorization for Disclosure of Protected Health Information**

*Please print all information. Form must be signed and dated each year.*

**AUTHORIZATION TO RELEASE Protected Health Information (PHI) to others:** I authorize Tri-State Orthopaedics & Sports Medicine and/or Tri-State Physical Therapy to disclose, discuss and provide PHI about me to the following individuals/entities:

_____ <b>Name/Address/Phone</b>	_____ <b>Relationship</b>
_____ <b>Name/Address/Phone</b>	_____ <b>Relationship</b>

**I authorize the practice to disclose the following PHI about me to those listed above:**

- Entire Patient Record/Information** Or check only those items of the record to be disclosed:
  - Office Notes     X-rays     Lab/Pathology Reports     Financial History (3 years)
  - Other physician notes in the record (including nursing home, home health and hospice)
  - Record of HIV/communicable disease testing     Record of mental health/substance abuse treatment
  - Only disclose the following: \_\_\_\_\_

**Purpose of Disclosure:**  Patient Request     Other (please specify): \_\_\_\_\_

This authorization will expire at the end of the calendar year of your last signature/date below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: \_\_\_\_\_

You have the right to terminate this authorization at any time by submitting a written request to our Medical Records Coordinator. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

The practice places no condition to sign this authorization on the delivery of healthcare or treatment. You have the right to receive a copy of the signed authorizations upon request.

We have no control over the person(s) you have listed to receive your PHI. Therefore, your protected information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and no longer will be the responsibility of the practice.

Patient (or Representative) Signature: _____	Date: _____
Patient (or Representative) Signature: _____	Date: _____
Patient (or Representative) Signature: _____	Date: _____
Patient (or Representative) Signature: _____	Date: _____
Patient (or Representative) Signature: _____	Date: _____