NOTICE OF PRIVACY PRACTICES

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

Effective: April 14, 2003 (updated 9/23/2013)

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, our Business Associates and subcontractors may use and disclose your Protected Health Information 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 Protected Health Information. "Protected Health Information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related healthcare services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and/or 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 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 to whom we have referred you for care; a physician/provider with whom we are consulting regarding you; or with another healthcare provider who seeks this 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 facility, nursing home, durable medical equipment agency, pain management or other healthcare provider to whom we have referred you for healthcare services/products; or a hospital or other healthcare facility where we are admitting, referring or treating you.

Payment: Your PHI will be used, as needed, to obtain payment for your healthcare services. Some examples of payment uses and disclosures include:

- Sharing information with your health insurer to determine whether you are eligible for coverage or whether proposed treatment is a covered service; submitting a claim form to your health insurer; or providing supplemental information to your insurer so that your health insurer 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 or other service may require that PHI be disclosed to the health plan to obtain approval/authorization.
- Sharing your demographic information (for example, 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 health 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.
- Disclosing information in a legal action for purposes of securing payment of a delinquent account.

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, fundraising, and conducting or arranging for other business-related activities. In addition, we utilize the following business operations, for example:

- We may use a patient sign-in sheet in the reception area, which maybe accessible to other patients. We may call patients by name from the reception area or use their name during their visit in common areas within the office.
- We may contact patients via phone, 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 record/document your care including electronic medical records, computerized radiology/PACS, 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 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, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, 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.

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.

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.

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 request must state the specific restriction requested and to whom you want the restriction to apply. If we agree to the 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 protected health information 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 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 agreed to accept this notice alternatively i.e. electronically.

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 revised 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 will also be posted at our offices and on our website.

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 at:

Tri-State Orthopaedics & Sports Medicine, Attention: Privacy Officer
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 HIPAA Compliance Officer.

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:

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

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:

_____	_____
Name/Address/Phone	**Relationship**
_____	_____
Name/Address/Phone	**Relationship**

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:_____