HUGHSTON CLINIC
ORTHOPAEDICS

HIPAA NOTICE OF PRIVACY PRACTICES
February 1, 2017

This notice describes how medical information about you may be used and disclosed and how you may get access to this information. Please review it carefully and sign where indicated to acknowledge your understanding of the information.

Hughston Clinic Orthopaedics is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Hughston Clinic Orthopaedics is required by law to abide by the terms of this Notice.

How your medical information will be used and disclosed:
We will use your medical information as part of rendering patient care. For example, the business office may use your medical information to process your payment for services rendered or administrative personnel may use your medical information to review the quality of the care provided.

We may also use and/or disclose your information in accordance with Federal and State law without your consent for the following purposes:

- **Appointment Reminders** – to provide appointment reminders
- **Treatment Information** – other alternative treatments or health-related services that may be of interest to you
- **Law Enforcement** – as required during an investigation
- **Legal Proceeding** – in the course of certain judicial or administrative proceeding.
- **Public Safety** – to prevent or lessen serious threat to the health or safety of the public
- **Military Activity and National Security** – to military command for their military records or other federal officials conducting national security and intelligence activities for protective services for the President
- **Workers' Compensation** – as authorized to workers' compensation or similar programs
- **Inmates** – to the correctional facility or law enforcement official for your proper care
- **Abuse or Neglect** – when it concerns abuse, neglect or violence in accordance to Federal or State law
- **Coroner, Medical Examiner or Funeral Director** – for identification of a body or to determine cause of death
- **Food and Drug Administration** – to report adverse events, product recalls or to make repairs or replacements
- **Research** – for certain research purposes if an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your information
- **Department of Health and Human Services** – for public health purposes to help control disease, injury or disability, as well as to a person who may have been exposed to a communicable disease or at risk of contacting or spreading a disease or condition
- **Health Oversight Activities** – for activities authorized by law, such as audits, investigations or inspections. Oversight agencies seeking this information include government agencies that oversee healthcare systems, government benefit programs and other government regulatory programs and civil rights law
- **Disaster Relief** – to a public entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts
- **Facility Directory** – your name and the location at which you are receiving care in our facility directory to be used only when someone calls and asks for you by name, unless you object
- **Business Associates** – to provide services on our behalf. We require our business associates to appropriately safeguard the health information of our patients and we require that they sign a contract as our Business Associate.

We will not use or disclose your medical information for any other purpose than those stated above without your written authorization.

AUTHORIZATIONS

Authorizations are required for:

- Most uses and disclosures of psychotherapy notes, where appropriate
- For marketing purposes
- Disclosures that constitute sale of protected health information

Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact:

Medical Records
Hughston Clinic Orthopaedics
1321 Murfreesboro Rd; Suite 510
Nashville, TN 37217
615-366-8890 or 800-323-8858

SUMMARY

By law, we are required to provide you with our Notice of Privacy Practices (NOPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

- The right to inspect and copy your information.
- The right to request corrections to your information.
- The right to request that your information be restricted.
- The right to request confidential communications.
- The right to a report of disclosures of your information.
- The right to a paper copy of this Notice.
- The right to file a complaint if you feel your privacy has been violated.
- The right to opt-out of fundraising communications. (The Hughston Clinic Orthopaedics does not contact patients for fundraising.)
- The right to restrict certain disclosures of your protected health information to a health plan when you have paid out of pocket in full for the healthcare item or service.
- The right to be notified following a breach of unsecured protected health information.

We want to assure you that your medical/protected health information is secure with us.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have read Hughston Clinic Orthopaedics' **NOTICE OF PRIVACY PRACTICES.** I understand that I may request a copy of this Notice. I further understand that if I have questions or complaints regarding my privacy rights, I may contact the Privacy Officer at 615-366-8890 or 800-323-8858.

_____
Patient or Representative Name (Please print)

_____ _____
Patient or Representative Signature Date

☐ Patient refused to sign
☐ Patient was unable to sign because _____

Documented by: _____

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FINANCIAL POLICY

Thank you for choosing Hughston Clinic Orthopaedics as your Orthopaedic specialty healthcare providers. We are committed to providing you with the best available medical care. In our ongoing process to make sure all of your medical needs are met, our staff will be available to discuss our fees and this policy with you. The services you have elected to participate in imply a financial responsibility on your part.

Payments for all services will be due at the time services are rendered. In order to better serve you, we accept cash, check, Visa, MasterCard, Discover and American Express. As a courtesy to you, we will verify your coverage and bill your insurance carrier on our behalf; however, you are ultimately responsible for the entire bill. As the responsible party, please understand:

(PLEASE INITIAL THE FOLLOWING)

_____Your insurance policy is a contract between you, your employer (if applicable) and your insurance provider. Hughston Clinic Orthopaedics is a party to that contract. Our relationship is with you, not your insurance provider. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance or "usual and customary" charges. As your medical provider, we will only supply factual information to facilitate claims processing.

_____I understand that I may have an insurance plan that restricts my therapy either by units or by a payable dollar amount and that it is my financial responsibility for the difference between services covered by my policy and the actual services provided.

_____Fees for services, which include unpaid balances, deductibles, co-payments and coinsurance, are due at the time of service. I understand should I receive therapy, a co-pay will be due at the time of service for each visit. I understand and agree if I fail to make payments for which I am responsible within three statement billing cycles, after such default and upon referral to a collection agency or attorney by Hughston Clinic Orthopaedics, I will be responsible for all costs of collecting monies owed including collection agency fees.

_____All charges are my responsibility. I f my insurance carrier does not remit payment within sixty days, the balance may be due in full from me. If any payment is made directly to me for services billed by Hughston Clinic Orthopaedics, I recognize an obligation to promptly remit payment to Hughston Clinic Orthopaedics.

_____I understand should I incur a balance that I am unable to pay within three billing cycles, I am required to contact Hughston Clinic Orthopaedics to set up a payment plan.

_____Completion of disability and/or FMLA forms are not billable/reimbursable by insurance carriers, therefore, fees are my responsibility for payment. Hughston Clinic Orthopaedics fees related to completion of these documents are expected to be paid upon presentation of forms for completion.

_____Returned checks and unpaid balances may be subject to collection placement and a collection fee for first placement and if legal action is required. I will be responsible for all costs of collecting monies owed including processing fees.

_____Hughston Clinic Orthopaedics utilizes the services of Assistant Surgeons/Physician Assistants/Nurse Practitioners for all medical services, including surgical procedures. We will bill your insurance for these services; however, should your insurance deny the charges as non-covered you will be held ultimately responsible.

_____I give consent to be contacted by my provider and their Designated Business Associates through any medium, including but not limited to wireless cell phone, email, and landline telephone. By providing your cellular number you are agreeing to be contacted by the provider and any entity working on the provider's behalf at that cellular number, and if necessary by an automated dialing or messaging system.

We understand financial problems may affect timely payment, so we encourage you to communicate any such problems, so we may assist you in keeping your account in good standing.

Printed Name of Patient: _____ Signature: _____

Relationship to Patient: _____ Date: _____

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ORTHOPAEDICS

Pictures and Audio/Visual Recording Acknowledgement

Thank you for choosing the Hughston Clinic Orthopaedics ("Clinic") as your orthopaedic healthcare provider. At the Clinic, we believe the physician-patient relationship is very important, which includes protecting all communication between you and your treating Clinic providers. To help in protecting your patient information, the Clinic prohibits the unauthorized taking of pictures and any audio or visual recording while receiving care or guidance from Clinic providers. If there are circumstances in which you feel that you may need to record an encounter with your Clinic provider, this must be approved by the physician in writing prior to your appointment. Please sign below acknowledging that you understand this policy.

Printed Name of Patient: _____ Signature: _____

Relationship to Patient: _____ Date: _____

HUGHSTON CLINIC
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DISCLOSURE OF INTEREST & OWNERSHIP

PHYSICAL THERAPY, MRI & PREMIER SURGERY CENTER

MR Number: _____ Date: _____

Patient Name: _____

The physicians of Hughston Clinic Orthopaedics ("HCO") have an ownership interest in the physical therapy (PT) departments that are located in many of our offices and in The HCO MRI Center. They may also have ownership in the Premier Orthopaedics Surgery Center.

HCO's physicians are required by law to disclose any ownership or financial interest they may have in any healthcare facility where their patients may receive care. HCO respects the rights of its patients to choose not only their physician, but also where they wish to have their therapy, diagnostic testing, and/or surgical procedures performed.

HCO's physicians and staff are dedicated to providing patient-focused, high quality care to their patients in a safe, convenient, affordable and patient-friendly environment.

HCO's physicians, through their ownership of services provided at their physical therapy departments, MRI facility and/or the Premier Surgery Center, are committed to maintaining the exceptional quality and service that patients and their families deserve and expect. To that end, HCO offers exceptional customer service and easy, prompt scheduling, as well as an expedient turnaround time for reports.

Your HCO physician prefers that you have your MRI imaging performed at The HCO MRI Center to ensure that you receive the highest level of care and quality. You will not be treatment any differently, however, regardless of the facility at which you choose to be treated. If you prefer, there are comparable MRI facilities throughout the area. Optional physical therapy and ambulatory surgery centers are available upon request. Below is a partial list of alternate MRI centers. When choosing an alternate facility, you are advised to check that it is covered under your insurance plan.

BioImaging Charlotte
1800 Charlotte Avenue
Nashville, TN 37203
Telephone (615) 329-4840

BioImaging Cool Springs
3310 Aspen Grove Drive, Suite 101
Franklin, TN 37067
Telephone (615) 711-0171

Diagnostic Health of Nashville
337 22nd Avenue North
Nashville, TN 37203
Telephone (615) 327-9550

MDL
1020 North Highland Avenue
Murfreesboro, TN 37130
Telephone (615) 896-1234

Lebanon MRI Center
1616 West Main Street
Lebanon, TN 37087
Telephone (615) 453-1653

Premier Radiology
28 White Bridge Road, Suite 111
Nashville, TN 37205
Telephone (615) 356-3999

Premier Radiology Hermitage
5045 Old Hickory Blvd., Suite 100
Hermitage, TN 37076
Telephone (615) 884-7674

Tennessee Oncology Imaging Center
2018 Murphy Avenue, Suite 200
Nashville, TN 37203
Telephone (615) 320-7387

If you feel that you have received proper notification of available MRI facilities in the area, as well as of the ownership and interest that your Hughston physician has in our physical therapy, MRI and/or The Premier Surgery Center facilities, please sign and date where indicated below to continue the scheduling of your procedure. Thank you for taking the time to read this form, which is legally required for the education of our patients.

_____ _____

Patient Signature Date

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AUTHORIZED PATIENT NOTIFICATION LIST

(Required of HIPAA) Health Insurance Portability and Accountability Act

I authorize all Hughston Clinic Orthopaedics' Physicians and/or whomsoever he/she may designate as his/her professional representative/assistant to discuss any aspect of my orthopedic care, to include: appointments, tests, test results, surgical procedures, prescriptions and any other pertinent information with the following persons in order to facilitate and coordinate my care, treatment and payment:

NAME	Relationship	Phone Number(s)
NAME	Relationship	Phone Number(s)
NAME	Relationship	Phone Number(s)
NAME	Relationship	Phone Number(s)

☐ I do not want to designate anyone to have authorization at this time.

This document will be a part of your permanent record. In the event any of the selected representatives that you have designated change, it will be necessary to update our records with a written notification. You will need to state who you would like to have removed from or added to the Authorized Notification List.

PATIENT'S NAME PRINT	SIGNATURE	DATE
LEGAL GUARDIAN/OTHER AUTHORIZED PERSON PRINT	SIGNATURE	DATE