**SPINE INSTITUTE OF THE CAROLINAS**
**HIPAA NOTICE OF PRIVACY PRACTICES**

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

If you have any questions regarding this notice, you may contact our privacy officer at:

Spine Institute of the Carolinas
Attn: Privacy Officer
300 Midtown Drive
Beaufort, SC 29906

## YOUR PROTECTED HEALTH INFORMATION

This Notice of Privacy Practices describes how Spine Institute of the Carolinas may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations; and for 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.

## USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Your PHI 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 purposes of providing health care services to you, to pay your health care bills, to support the operations of the physicians' 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 your health record with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you, or your PHI 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 PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

### Healthcare Operations

We may use or disclose, as needed, your PHI in order to support the business activities of your physicians' practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conduction of other business activities. For example, we may call you by name in the waiting room when your physician is ready to see you. We may use your PHI, as necessary, to contact you and remind you of your appointment.

### Uses and Disclosures for Other Purposes

We may use or disclose your PHI in the following situations without your authorization. These situations may include: individuals in care or payment for care; notification purposes; issues required by federal, state, or local law; public health issues as required by law; communicable disease reporting; health oversight activities; victims of abuse, neglect or domestic violence; Food and Drug Administration requirements; judicial and administrative proceedings; law enforcement purposes; coroners and medical examiners; funeral directors; organ and tissue donation; threat to public safety; military activity and national security; workers compensation and similar programs; business associates. Under 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 requirement of Section 164 500.

### Uses and Disclosures with Authorization

For all other purposes that do not fall into one of the sections listed above, we will obtain your written authorization to use or disclose your PHI. You may revoke this authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

## PATIENT PRIVACY RIGHTS

### Further Restriction on Use or Disclosure

You have a right to request that we further restrict use and disclosure of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI 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.

To request a further restriction, you must submit a written request to our privacy officer. The request must explain: what information you want restricted; how you want the information restricted; and to whom you want the restriction to apply. We are not required to agree to a request for a further restriction.

### Confidential Communication

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. We are not required to agree to request for confidential communications that are unreasonable. To make a request for confidential communications, you must submit a written request to our privacy officer. The request must explain how or where you want to be contacted. In addition, if another individual or entity is responsible for payment, the request must explain how payment will be handled.

### Accounting of Disclosures

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right is limited to disclosures within six years of the request and other limitations. To request an accounting, you must submit a written letter to our privacy officer. The request should designate the applicable time period.

### Inspection and Copying

You have a right to inspect and obtain a copy of your PHI that we maintain in a designated records set. This right is subject to limitation and we may impose a charge for the labor and supplies involved in providing copies. To exercise your right of access, you must submit a written request to our privacy officer. The request must: describe the health information to which access is requested; state how you want to access the information, such as inspection, pick-up of copy, mailing of copy; specify the requested form or format; include the mailing address, if applicable.

### Right to Amendment

You have the right to request that we amend your PHI that we maintain about you if the information is incorrect or incomplete. This right is subject to limitations. To request an amendment, you must submit a request to our privacy officer. The request must specify each change that you want and provide a reason to support each requested change.

### Paper Copy of Privacy Notice

You have the right to receive, upon request, a paper copy of our Notice of Privacy Practices. To obtain a paper copy, contact our privacy officer.

## CHANGES TO THIS NOTICE

We reserve the right to change the terms of this notice at any time. We further reserve the right to make any change effective for all PHI that we maintain at the time of the change – including information that we created or received prior to the effective date of change. We will post a copy of our current notice at the reception desk of the practice. At any time, patients may review the current notice by contacting our privacy officer.

## COMPLAINTS

If you believe that we have violated your privacy rights, you may submit a complaint to the practice or the Secretary of Health and Human Services. To file a complain with the practice, submit the claim in writing to our privacy officer. We will not retaliate against you for filing a complaint.

## LEGAL EFFECT OF THIS NOTICE

This notice was published and becomes effective on/or before March 12, 2013. This notice is not intended to create a contract or other rights independent of those created in the federal privacy rule.

## SPINE INSTITUTE OF THE CAROLINAS

# AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION
# ACKNOWLEDGEMENT OF PRIVACY PRACTICES

**1. PATIENT INFORMATION**

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Med. Rec. #: _____

**2. INFORMATION TO BE RELEASED FROM (SELECT ONLY ONE)**

☐ Spine Institute of the Carolinas

☐ Organization/Person: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

**3. INFORMATION TO BE RELEASED TO (SELECT ONLY ONE)**

☐ Spine Institute of the Carolinas, 300 Midtown Drive, Beaufort, SC 29906 Fax: (843) 522-1275

☐ Organization/Person: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

**4. PURPOSE OF RELEASE**

☐ Continuing Care
☐ Copies for own use
☐ Insurance
☐ Legal
☐ Other (specify)

_____

**5. INFORMATION TO BE RELEASED**

Date from: _____ to: _____

☐ Office Notes
☐ Lab/Pathology reports
☐ Radiology reports
☐ Billing records

☐ ENTIRE RECORD
☐ Other (specify)

_____

**I ☐ do ☐ do not authorize this information to be disclosed electronically.**

I understand that authorizing the disclosure of this patient health information is voluntary. I understand that this authorization may include release of the following sensitive medical information unless I have initialed below to exlude such information:

☐ mental health treatment (including pain management)
☐ alcohol and/or drug abuse treatment
☐ sexually transmitted diseases
☐ AIDS/HIV treatment

I can cancel this authorization at any time by writing to

Spine Institute of the Carolinas
Attn: Privacy Officer
300 Midtown Drive
Beaufort, SC 29906

I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled. Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws. This authorization will expire 3 years from the date signed below unless otherwise requested in writing. I understand that I may receive a copy of this completed form, after signing it, at my request. I understand that a photocopy of this authorization is as valid as the original.

I have been provided a copy of Spine Institute of the Carolinas' Notice of Privacy Practices.

**6. SIGNATURE**

Patient or Legally Responsible Party _____ Date _____

Relationship to Patient, if not signed by patient _____

Send Completed **Authorization to Release Patient Health Information** form by mail or fax to:

ADDRESS: Spine Institute of the Carolinas
300 Midtown Drive
Beaufort, SC 29906

FAX NUMBER: (843) 522-1275
Attn: Medical Records

**SPINE INSTITUE OF THE CAROLINAS**
**FINANCIAL POLICY**

Spine Institute of the Carolinas has a financial policy that clearly outlines patient and practice financial responsibilities. We are committed to providing the best possible medical care, while minimizing adminstrative costs. This financial policy has been established with these objectives in mind, and to avoid misunderstanding and disagreement concerning payment of professional services.

Basic Policy: Payment for services is due in full at the time the service is rendered in our office. Cash, personal check, money orders, debit cards, Visa and MasterCard are acceptable forms of payment.

Patients with Medical Insurance: Spine Institute of the Carolinas has a provider relationship with many, but not all, insurance companies, including SC Medicare and Medicaid. It is the responsibility of the patient to determine, prior to your scheduled appointment, if this office participates with your plan. Our office requires patients to assign all insurance payments directly to the practice. It is your responsibility to pay charges not covered by your insurance carrier. The patient will be required to provide a current, up-to-date insurance card. It is the responsibility of the patient to keep our office updated regarding any changes in insurance or personal information.

Claims Submissions: As a courtesy, this office will submit your claims and assist you in any way we reasonably can to get your claim paid. Your insurance company may require additional information directly from you. It is your responsibility to comply with these requests. Please be advised that the balance of your claim is your responsibility whether or not your insurance company pays. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Medicare: As a participating provider with Medicare, we will file your claim to the Medicare carrier. Beneficiaries will be responsible for the following: payment of the 20% co-insurance and deductible amounts, completing and ABN for services that may not be covered under Medicare plan and any charges not covered under the Medicare Program.

Secondary Insurers: Having more than one insurance plan does not necessarily mean that your services are covered in full. We will bill your secondary insurance as a courtesy. You will be responsible for any balances after your insurance(s) clear.

Account Payment/Non-Payment: Each month, patients will receive a statement, which is due within 30 days. If payment is late, the account will be places in an in-house collection status. Any account reaching 120 past due may be sent to an outside collection agency. Accounts referred to an outside collection agency will be assessed a 25% collection fee. Patients will be responsible for all attorney or court costs associated with collecting this debt. The patient may be discharged from the practice for non-payment of account. Any returned check will have a $25 service fee added. The patient will have 10 days to make payment of the total due (check and service fee) by cash or money order only.

Charity Care: Charity care is funded by the state of South Carolina and provides limited compensation to hospitals for services. It does not compensate physicians for any services.

Workers' Compensation/Motor Vehicle Accidents: It is the patient's responsibility to notify this office, prior to seeing the provider, if their visit is related to a work or automobile incident. We may need additional information to appropriately file these claims.

Our office staff is instructed to make every effort to clarify any misunderstandings patients may have about their account balance. Any questions or concerns about this financial policy should be directed to the Billing Department. Thank you for your cooperation as we make every effort to continue to provide you with the very best medical care.

**I have read and fully understand the financial policy set forth by Spine Institute of the Carolinas and agree to comply with the financial policy set forth above. I also understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the patient:**

_____

Patient's signature (or authorized representative's signature) Date

_____

Patient's name (or authorized representative's name, and relationship to patient)