HIPAA POLICY NOTICE OF PRIVACY PRACTICES Version 1.2023

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

Brighton Foot and Ankle (the "Practice") in accordance with the Health Insurance Portability and Accountability Act of 1996 are required by applicable federal and state laws to maintain the privacy of your protected health information ("PHI"). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your PHI about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your PHI to provide, coordinate or manage your health care and any related services. Examples of treatment include: (a) the provision, coordination, or management of healthcare and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Payment: Your PHI will be used to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. Other examples of payment include: (a) billing and collection activities and related data processing; (b) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement; (c) to provide the Medicare program with information about health care services that you received so the Practice can be reimbursed.

Health Care Operations: To operate in accordance with applicable law and insurance requirements, and to provide quality and efficient care, the Practice may need to compile, use and disclose your PHI. Examples of health care operations include: (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communication in connection to case coordination; (c) reviewing the qualifications of and training health care professionals; (d) medical review, legal services, and auditing functions; and (e) general administrative activities such as customer service and data analysis.

Sale of Health Information: We will not sell or exchange your health information for any type of financial remuneration.

Uses and Disclosures Based On Your Written Authorization: You may give us written authorization to use your PHI 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. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: We may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your PHI to contact you with information about treatment alternatives that may be of interest to you. We may disclose your PHI to a business associate to assist us in these activities. We may use your PHI to send newsletters or flyers about our services and products.

Research; Death; Organ Donation: We may use or disclose your PHI for research purposes in limited circumstances. We may disclose the PHI of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your PHI to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your PHI to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse, victim of abuse, neglect or domestic violence. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your PHI when we are required to do so by law. For example, we must disclose your PHI to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your PHI when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your PHI to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the PHI of a suspect, fugitive, material witness, and crime victim or missing person. We may disclose the PHI of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose PHI where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your PHI, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your PHI. You may also request access by sending us a letter to the address at the end of this notice.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes other than treatment, payment, health care operations and certain other activities for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your PHI by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you would like more information about our privacy practices or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to protect the privacy of your protected health information.

Name of Contact Person: Abby Stephen

Phone: 810-227-3864

Fax: 810-958-1174

Address: Brighton Foot and Ankle

7990 Grand River Rd Ste D

Brighton MI 48114

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Notification of Office Policies & Procedures version 1.2023

1. Reading the following policies and procedures annually will keep you informed about our office.

2. Office Hours: Our office is open: Monday: 9:00AM-7:00PM
Tuesday: 8:30AM-5:00PM
Wednesday: 7:30AM-2:00PM
Thursday: 8:30AM-5:00PM
Friday: 8:30AM-2:00PM

3. Holidays: Our office will be closed the following holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, Christmas Eve, and Christmas Day.

4. Appointments: Physicians are available by appointment during posted hours. During a medical emergency, patients should seek care at the nearest emergency room or call 911. We strive to accommodate same-day appointment requests for urgent care needs. Contacting our office early in the day will help us accommodate your needs. We will make every effort to see you at your scheduled appointment time and ask for your understanding in the event we are running behind schedule. Unforeseen emergencies and complex patients may warrant additional time with the provider. Our staff is committed to keeping you informed of delays and offering our patients options to manage their valuable time.

5. Cancellations: In order to be respectful of the medical needs of our patients please be courteous and call us promptly if you are unable to attend an appointment. This time can be reallocated to someone who is in need of treatment.

6. Inclement Weather: In the case of extreme weather our office will be closed to ensure the safety of our staff and patients. In such instances, we will utilize patient approved communication methods to notify the patient. We also strive to post statuses to our FaceBook, Instagram and Google pages. We encourage you to like and follow our social media for updates.

7. Treatment of Minors: Patients under the age of 18 must be accompanied by a responsible adult or have written permission for treatment from a parent or guardian.

8. Refills & Medications: Refill requests will only be considered for patients seen within 30 days prior to the request. All other requests will require an appointment. Please allow 48 hours to process each request.

9. Insurance: The Practice accepts most insurance plans. It is the patient's responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payment. We will collect based on your insurance benefits including all applicable copays, deductibles, coinsurance and balances that apply at the time of service. All co-payments are due at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

10. Self Pay: Payment in full is due at the time of service if you do not have health insurance. A fee schedule is available.

11. Patient Billing: You will be sent up to three notices for your financial responsibility after an explanation of benefits (EOB) is received from your insurance company. After the third and last notice, your account may be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on an individual basis.

12. Payment: The Practice accepts VISA, MasterCard, Discover, American Express, CareCredit, Cash or Checks.

13. Returned Checks: A $35 fee will be assessed on all returned checks.

14. Delinquent Accounts: Past due accounts are subject to collection proceedings and are reported to the credit bureau. All collection fees, attorney fees and court fees shall become the patient's or responsible party's responsibility in addition to the balance due to the office. Delinquent accounts will result in future services on a pre-payment basis only.

15. Non –Covered Services: The Practice will not submit claims for non-covered items including over the counter convenience items (OTC eg. Orthotics, Coban, Kera42, NeuRx, ect.)

16. Referrals: The patient is responsible for all insurance prior authorizations and/or managed care referrals necessary for payment to the Practice. Patients that present without their required referral will be asked to reschedule their appointment or to sign a referral waiver. The referral waiver states that the patient agrees to be fully responsible for all charges if their referral is not received.

17. Claims Submission: The Practice will file claims based on the patient's insurance assignment. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. The Practice will bill your insurance, but it is ultimately your responsibility to make sure your insurance company pays. If they do not pay you must pay the bill in full.

18. Tardiness: If you are more than 15 minutes late for your scheduled appointment you will be asked to reschedule.

19. Refunds: The Practice issues patient refunds by check within 30 days of a completed investigation of potential overpayment, as long as other outstanding accounts have been resolved.

20. Custom Medical Devices: You will be notified when your custom equipment is available. The device must be picked up within 30 days of the notice. When you agree to have a custom medical device made you are agreeing that you will be financially responsible for the cost of the device regardless of insurance coverage. No returns are accepted on custom devices.

21. Maintaining a Respectful Environment: The doctor and staff strive to treat our patients with courtesy and respect. It is also important that our staff is treated with respect from our patients. We feel very strongly that our staff should be able to work in an environment free from verbal and physical abuse. Angry outbursts against our staff will not be tolerated and may result in your discharge from the practice.

22. Dismissal From Practice: The physician can identify a patient with whom the physician-patient relationship has been negatively or is no longer therapeutic. The types of circumstances that can result in termination include, but are not limited to, the following:

- Repeated noncompliance with therapies or treatments essential to the patient's safety as deemed medically necessary by the physician.
- Failure to meet financial obligations to the Practice regarding care provided or to cooperate with payment processes consistent with our payment policies.
- Consistent or repeated failure to keep appointments without good cause and/or without notice of intent to cancel appointments.
- Threatening, violent, abusive or patterns or repetitive rude or offensive behavior directed at a provider, other staff members, or other patients or visitors.
- Attempts by the patient to use the relationship to illegally or improperly obtain medication or controlled substances for non-therapeutic purposes, abuse of controlled substances or otherwise refusing to obtain treatment for controlled substance abuse or addiction, seeking multiple prescriptions from different physicians or diverting controlled substances.
- The patient elects to terminate or expresses a desire to terminate the relationship.

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Authorization from Patient or Legal Representative Version 1.2022

1. Consent to Treat: The undersigned consents to any initial or follow-up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient by the Practice and its providers. The undersigned agrees that it is their responsibility to contact and/or schedule with the Practice for any follow-up visits, other services, prescriptions and items ordered for the patient. The undersigned also understands that the Practice providers exercise their care with reasonable skill and diligence, but make no guarantee as to the results or cure that will be attained.

2. Assignment of Benefits: The undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to the Practice all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize release of medical information to my insurance carrier.

3. Medicare Assignment: I certify that the information given by me in applying for payment under XVIII of the Social Security Act is correct and agree to complete the Medicare screening form annually. I authorize the release of information concerning me to the Social Security Administration or its intermediaries as well as any information needed for filing a Medicare claim; I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to the Practice.

4. Authorization to Release Information: I consent and authorize the Practice and its agents to release my health information for the purpose of payment, treatment, and healthcare operations to any of the following: insurance company, any practitioner, support staff or facility involved in my plan of care or transfer of care. I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy notice. The HIPAA Notice of Privacy Practices are available online at www.BrightonFootandAnkle.com. Individual copies are also available in the office. I have read/had the opportunity to read my HIPAA rights.

5. Designation of Authorized Representative: I designate and appoint the Practice (and its agents) as my authorized representative and authorize it to act on my behalf to 1) request and receive a copy of the summary plan description, 2) pursue a benefit claim, 3) appeal and adverse benefit determination, and/or 4) file a legal/equitable action to recover benefits from my insurance policy and any third-party reimbursement. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to a determination of the claim for health benefits relating to treatment and health care services received by me/my child at the Practice.

6. Financial Agreement: I hereby understand my responsibility to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment. According to the language of the physician's insurance contract, I understand that I am responsible for all health insurance copayments, deductibles, coinsurances, over the counter convenience items and noncovered services and any other amounts that apply at the time of service. Regardless of the assignment of benefits, should the insurance misrepresent their coverage or delay payment of a claim greater than 60 days, as the designated responsible party, I am responsible for all monies owed to the Practice. I also understand that the insurance policy is a contract between me and the insurance company; therefore the policy holder should contact the insurance carrier first when there are questions regarding the explanation of benefits.

7. Authorization to Use Information/Images: I consent to allow the Practice to use my provided email and contact information for educational and marketing contact purposes. I consent to the use of photographic images of me, taken by the Practice, for care, teaching and/or advertising purposes.

8. Authorization to Contact: I agree to allow any information I provide to the Practice to be used for contacting me regarding appointments, treatment matters, marketing, and other information. This includes home phone, cell phone, texting, emails, mail and other means. I understand that Msg & Data rates may apply with texting and cell phone communication . You may opt out of communication by contacting the office.