

HIPAA NOTICE OF PRIVACY PRACTICES

UNIVERSITY ORTHOPAEDIC ASSOCIATES, LLC

215 Easton Avenue
New Brunswick, NJ 08901
732-545-0400

211 N. Harrison Street
Princeton, NJ 08540
609-683-7800

562 Easton Avenue
Somerset, NJ 08873
732-565-5450

4810 Belmar Blvd, Suite 102
Wall, NJ 07753
732-938-6090

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.

OUR COMMITMENT TO PROTECTING YOUR PERSONAL HEALTH INFORMATION

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care 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" 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.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information 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 purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's 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 related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information 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 protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Other Uses and Disclosure We Can Make Without Your Written Authorization or Opportunity to Agree or Object:

We may use or disclose your protected health information 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, and Organ Donation; Research: Criminal Activity; Military Activity and National Security; Workers Compensation; Inmates; Required Uses and Disclosures; Under the 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 requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke your 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 indicated in the authorization.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information 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.

Your physician is not required to agree to a restriction that you may request.

You have the right to request to receive confidential communications 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 may have the right to have your physician amend your protected health information. 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 we have made, if any, of your protected health information.

3. 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 contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officers, Darleen Caccavale, or Heidi Stout, in person or by phone at 732-545-0400.

06.05.08jwa

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Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Print Name of Patient: _____ Date: _____

Signature of Patient: _____ SSN: _____

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: _____ Date: _____

Signature of Personal Representative: _____ Relationship to Patient: _____

For Practice Use Only:

Signature of Practice Employee: _____ Date: _____

The following is an authorization for miscellaneous services this office uses. We will make every effort to abide by your instructions. Please provide the following information:

Appointment Reminders/Test Results (laboratory, X-rays, etc)

If we need to reach you regarding an appointment or test results, we will make every effort to reach you personally. If we cannot reach you personally, we will only leave a message asking you to call our office during regular business hours. Please check all items below that apply to you.

May we send an appointment reminder card to your home address? (circle) Yes No

May we call to remind you of an appointment or regarding test results? (circle) Yes No

Please call me at the following number(s):

Home phone: _____ Cell Phone: _____

Work phone: _____ Email address: _____

If we get an answering machine/voice mail, may we leave a message? (circle) Yes No

If we get a family member, may we leave a message? (circle) Yes No

Policy for Discussing Your Medical Information with Family Members

Our office will never discuss your medical information with a family member unless you have authorized us to do so. Please indicate the family members authorized to discuss your medical care by checking all items that apply to you and providing the name(s) where applicable.

() Spouse _____

() Parent(s) _____

() Child(ren) _____

() Sibling(s) _____

() Other(s) _____

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