Orthopaedic Associates, Inc.

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act

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.

1. Information collected by Orthopaedic Associates (OA) about you including demographic data (address, phone number, etc.) and health information is considered Protected Health Information (PHI). We may use this information to:

- Aid in your treatment, including corresponding with other healthcare providers
- Use it to identify you to appropriate insurance companies for payment of services
- Use it for the purposes of our internal operations

PHI may also be used specifically to contact you regarding appointment reminders or changes, sending literature from OA to you recommending treatment alternatives or providing information about health related benefits.

2. Any other uses or disclosures of your PHI will only be done with your specific signed authorization. This authorization can be revoked by you at any time, in writing.

3. Under this regulation you may receive confidential communications of PHI, inspect and copy PHI, amend PHI, obtain an accounting of disclosures of PHI. You are also entitled to put any restrictions on the use of your PHI at this time, written in the space below. Be advised that if these restrictions are not acceptable to OA (i.e. we feel it would unduly interfere with your medical care) we may not provide treatment.

4. OA is legally obligated to maintain the privacy of PHI, provide this notice of privacy practices, and abide by the terms of this notice. OA reserves the right to change this privacy practice and apply the revised practices to PHI.

5. If you have a complaint to register with OA regarding violation of your privacy rights you may contact our compliance officer and/or file a complaint with the Department of Health and Human Services. Note that no retaliation will be taken against any individual for this action.

6. Further information about any of these matters may be obtained from our compliance officer. This information is effective as of April 14, 2003.

I acknowledge that I have read and understand this privacy notice and have been given an opportunity to request specific restrictions on the use and disclosure of my personal health information.

Name: _____ Date: _____

◊ Patient refused to sign

◊ Patient was unable to sign because _____