ORION
SPINE AND PAIN

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.

ORION SPINE AND PAIN and its employees are dedicated to maintaining the privacy of your personal health information ("PHI"), as required by applicable federal and state laws. These laws require us to provide you with this Notice of Privacy Practices and to inform you of your rights and our obligations concerning PHI, which is information that identifies you and relates to your physical or mental health condition. We are required to follow the privacy practices described below while this Notice is in effect.

A. Permitted Disclosures of PHI

We may disclose your PHI for the following reasons:

1. Treatment: To physicians, nurses, and other healthcare providers involved in your care.
2. Payment: To bill and collect payment for services, including insurance companies and billing services.
3. Health Care Operations: For quality control, audits, performance reviews, and legal compliance. Including marketing to direct services and treatments.
4. Emergency Situations: If you require urgent care and cannot communicate.
5. Family/Friends: With those involved in your care or payment for your care(unless you object)
6. As Required by Law: Including abuse reporting, law enforcement, subpoenas, and court orders.
7. Public Health Activities: Reporting diseases, injuries, and vital statistics.
8. Health Oversight: Inspections, audits, and investigations.
9. Research: Under strict confidentiality protocols.
10. Workers' Compensation: For claims processing.
11. Military/National Security: As required by authorities.
12. Organ Donation and Funeral Directors: As necessary for their duties.
13. Serious Threat: To prevent harm to individuals or the public.
14. Disaster Relief: To authorized organizations like the Red Cross.
15. Appointments and Services: To remind or inform you of treatment and services.

B. Disclosures Requiring Written Authorization

1. Not Otherwise Permitted: Any other disclosure not described above.
2. Psychotherapy Notes: Except under limited legal or operational needs.
3. Sale of PHI: Requires explicit written authorization.

C. Your Rights

1. Right to Receive a Paper Copy of This Notice.
2. Right to Access PHI: You may inspect or copy your PHI. Charges may apply.
3. Right to Request Restrictions: On how your PHI is used or disclosed.
4. Right to Restrict Disclosure for Self-Paid Services.
5. Right to Request Amendments: To correct inaccurate or incomplete PHI.
6. Right to an Accounting of Disclosures.
7. Right to Confidential Communications: Request specific contact methods.
8. Right to Notice of Breach: You will be notified of any breaches involving your PHI.

D. Changes to This Notice

We reserve the right to change this Notice at any time. Revisions will apply to all PHI we maintain and will be made available upon request.

E. Questions or Complaints

If you have questions, or believe your rights have been violated, contact us at:

Orion Spine and Pain
Phone: [Insert Phone Number]
Address: [Insert Address]

You may also file a complaint with the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

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HIPAA and Notice of Privacy Policies Acknowledgment Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by Orion spine and pain and given a copy of their Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address(s) below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment, or health care organizations.

I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it's bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Printed Name	Date of Birth (MM/DD/YYYY)
Signature of Patient (or Legal Representative for Patient)	Date
Legal Representative	Relationship to Patient