MSOC

Michigan SportsMedicine
and Orthopedic Center

www.michigansportsmedicine.com

- John K. Anderson, MD
- John K. Morris, MD

- Orthopedic Surgery
- Physical Therapy
- Sports Fitness

4972B West Clark Road
Suite 200
Ypsilanti, MI 48197
734.434.3020
734.434.3025 Fax

OFFICE POLICIES

We would appreciate you taking a moment to review our office policies listed below.

APPOINTMENTS

- Patients are seen on an appointment basis only. We try to maintain our daily schedule, however, being an Orthopedic practice emergencies frequently arise. We appreciate your patience and understanding
- Due to many changes in insurance coverage and federal regulation of identity verification, it will be necessary to present your insurance card and picture id at each appointment.
- If you are unable to keep your appointment, please cancel within 24 hour notice
- If you do not show for an appointment and do not call you may be charged a $25.00 no show fee
- If you are more than 15 minutes late for your appointment you may be asked to reschedule your appointment

PRESCRIPTIONS

- If you need a new prescription or a refill of your current medication, please allow the office (2) days to process your request. All prescription requests need to be verified by your physician before they are filled.

MEDICAL RECORDS

- We will complete one medical disability form per month at no charge to you. There will be a $10.00 fee for each additional form. Please allow 7-10 business days to complete disability forms. We also need a signed authorization by you to release any medical information to your employer.
- Due to new laws mandated by the US Government pertaining to the privacy of your health information we must have a signed authorization by your, along with the name, address and phone number of all parties you wish your medical records be released to.

I acknowledge that I read and/or received a copy of Michigan Sports Medicine and Orthopedic Center, P.C. Office Policies. I agree with the terms within.

Printed Name: _____ Date: _____

Signature _____

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OFFICE BILLING POLICY

Insurance copayments will be collected at the time of service. If you are unable to pay your copayment today, please **reschedule your appointment. For your convenience, our office accepts personal checks, Visa, MasterCard, Discover,** Cash and Care Credit.

Self pay (no insurance) patients must pay on the date of service. If we get a returned check our fee is $30.00.

All previous balances are due prior to your next appointment. After 3 statements are sent there will be a $5.00 monthly statement fee for each additional statement sent.

Our Finance charges will be charged at a rate of .5% monthly and 6% annually for unpaid bills over 90 days past due.

If after 90 days, we have not received payment from your insurance company; our office reserves the right to send the entire bill to the patient for payment. It will be your responsibility at that point to contact your insurance company with any questions or concerns regarding your bill.

Due to many changes to insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay on top of these changes, it is not always possible. **It is your responsibility to know the special terms, deductibles, and our** copayments of your insurance coverage. Failure to notify us will result in non-covered expenses which will be your responsibility.

If your insurance requires you to have a written referral or authorization such as an HMO, Workers Compensation or Auto Insurance it is the responsibility of the patient to obtain it PRIOR to the appointment. If you do not have the referral, you may need to reschedule your appointment or you will be responsible for the charges.

It is your responsibility to pay any deductible, co-insurance, or any other balance not paid by your insurance carrier.

Please remember your insurance policy is between you and your insurance company and not with the insurance company and your doctor.

The intention of this notice is to clarify our policies and procedures and promote good communication between our patients and our office.

I understand the billing procedures associated with this office and completely understand additional charges will be incurred if I fail to comply. I also, acknowledge that if I do not pay in full for services rendered, on the date of service, I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, Private Insurance and any other health plan to Michigan Sports Medicine and Orthopedic Center, P.C.. A photocopy of this policy is to be considered as valid as the original. I further authorize Michigan Sports Medicine and Orthopedic Center, P.C. be allowed to release information regarding my treatment in order to receive payment.

Print Patient Name

Signature of Patient and/or Guardian if under 18

Date

Relationship to Patient

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*****If this visit is related to Worker's Comp, an Auto Injury, or a Public Liability claim, please alert the front desk staff immediately!*****

INJURY FORM

Today's Date: _____

Name: _____ DOB: ___/___/___ SS#: _____
LAST FIRST M.I.

Address: _____
STATE ZIP

Primary Phone: _____ Secondary Phone: _____

Work Phone: _____ Email: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race: ☐ Native American ☐ Asian ☐ African American ☐ Native Hawaiian ☐ White ☐ Type-Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Type-Unknown

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Creole ☐ Other: _____

May we leave routine messages on your personal answering machine/voice mail? ☐ Yes ☐ No

May we share your protected health information with a family member? ☐ Yes ☐ No

Please list names: _____

Name of emergency contact: _____ Relationship: _____

Phone: _____ Alternative phone: _____

Are you coming from a skilled nursing facility? ☐ Yes ☐ No

Name of facility: _____ Address: _____

DATE OF INJURY: INITIALS:

Primary Insurance: _____

Policy Holders Name: _____ DOB: _____

Second Insurance: _____

Policy Holders Name: _____ DOB: _____

Third Insurance: _____

Policy Holders Name: _____ DOB: _____

Patients under 18 must be accompanied by a parent or guardian

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HEALTH HISTORY (CONFIDENTIAL)

Patient Name: _____ Today's Date: _____

Symptom or problem for which you are seeing the doctor today _____

Referred by: _____ Pharmacy name and phone number: _____

Primary Care Physician: _____ Cardiologist: _____

SYMPTOMS: CHECK (✔) SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR

GENERAL
- ☐ Anxiety
- ☐ Balance problems
- ☐ Chills
- ☐ Depression
- ☐ Difficulty Walking
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Headache
- ☐ Hot Flashes
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ AnxietyNumbness

WOMEN ONLY
Menopause: ☐ Yes ☐ No

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders
- ☐ Groin

GENITO-URINARY
- ☐ Lack of bladder control
- ☐ Difficulty/Pain urinating

GASTROINTESTINAL
- ☐ Bowel Changes
- ☐ Lack of Bowel Control
- ☐ Heartburn/Indigestion
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Stomach Pain

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Rapid Heart Beat
- ☐ Sleep Apnea
- ☐ Swelling of ankles

EYE, EAR, NOSE, THROAT
- ☐ Difficulty Swallowing
- ☐ Loss of Hearing
- ☐ Sinus Problems

SKIN
- ☐ Bruise Easily
- ☐ Itching
- ☐ Rash

Current Height: _____
Current Weight: _____

Physician Notes:

SYMPTOMS: CHECK (✔) CONDITIONS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bi-Polar Disorder
- ☐ Bleeding Disorders
- ☐ Blood Pressure, High
- ☐ Bronchitis
- ☐ Cancer _____
- ☐ Cerebral Palsy
- ☐ Chemical Dependency
- ☐ Cirrhosis of Liver
- ☐ COPD
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fractures _____
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis Type A, B, C
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Legally Blind
- ☐ Liver Disease
- ☐ Lupus
- ☐ Meningitis
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer in Stomach
- ☐ Ulcers of Skin
- ☐ Other _____

FAMILY HISTORY: CHECK (✔) ALL THAT APPLIES AND INDICATE THEIR RELATIONSHIP TO YOU

- ☐ Heart Disease _____
- ☐ Arthritis _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Osteoporosis _____
- ☐ Scoliosis _____

SOCIAL HISTORY:

Do you exercise? ☐ Yes ☐ No Type of exercise: _____ Times per week: _____

Tobacco Use: ☐ Current every day smoker ☐ Current some day smoker ☐ Never smoker ☐ Former smoker

Alcohol Use: ☐ None ☐ Social ☐ Moderate ☐ Heavy

Employer/Occupation: _____ Are you able to work now? ☐ Yes ☐ No

Is your current problem related to work or an accident? _____ Is there an attorney working with you? ☐ Yes ☐ No

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HEALTH HISTORY (CONFIDENTIAL) – continued

LIST ALL MEDICATIONS (PRESCRIPTIONS AND NON-PRESCRIPTIONS) YOU ARE PRESENTLY TAKING, INCLUDE FREQUENCY AND DOSE

MEDICATION NAME	DOSE	HOW OFTEN PER DAY
■		
■		
■		
■		
■		
■		
■		
■		
■		
■		
■		
■		
■ Are you taking any blood thinners (Coumadin, Heparin, Plavix, Aspirin)		
■		
■		
■		

Do you have any allergies to medications and foods? ☐ Yes ☐ No Dye? ☐ Yes ☐ No Iodine? ☐ Yes ☐ No
If yes, please list: _____

Do you have skin sensitivity or allergy to metals? ☐ Yes ☐ No Latex? ☐ Yes ☐ No
If yes, please list: _____

LIST ALL SURGICAL PROCEDURES YOU HAVE HAD AND THE APPROXIMATE DATE:

SURGICAL PROCEDURE	DATE
■	
■	
■	
■	
■	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient or Legal Guardian Signature: _____

Review by: _____ Date: _____

Patients under 18 must be accompanied by a parent or guardian

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use of disclosure of the named individual's health information as described below:

Patient: _____ DOB: ___/___/___ SS#: _____
LAST FIRST M.I.

Address: _____
STATE ZIP

Telephone: _____

THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING PURPOSES:

☐ The request of the patient or patient representative

☐ Other _____

THE FOLLOWING INFORMATION IS TO BE DISCLOSED:

☐ Physician notes

☐ MRI scans

☐ Lab results

☐ Complete record

☐ Xray reports

☐ Other _____

☐ Treatment dates _____

REDISCLOSURE:

I understand that any disclosure of information carries with in the potential for redisclosure and that the information then may not be protected by the federal confidentiality rules.

RIGHT TO REVOKE:

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I also understand that the revocation will not apply to information already released based on this authorization.

OTHER RIGHTS:

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I also understand that I may inspect or obtain a copy of the information to be used or disclosed.

EXPIRATION:

Unless otherwise revoked, this authorization will expire 6 months after signed date.

Patient or Legal Guardian Signature: _____ Date: _____

If signed by legal representative relationship: _____ Date: _____

Michigan SportsMedicine and Orthopedic Center
Notice of Privacy Practices – Effective Date: 01/2017

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.

DEFINITIONS

Notice of Privacy Practices (The Notice) – a written notice in compliance with the requirements of Health Insurance Portability and Accountability Act (HIPAA), and the Health Information Technology for Economicand Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, made available from Michigan SportsMedicine and Orthopedic Center (MSOC) to an individual or the individual's personal representative at the first delivery of service, or at the individual's next visit following a revision to the Notice, that describes the uses and disclosures of protected health information that may be made by MSOC and the individual's rights and MSOC's legal duties with respect to protected health information. Protected Health Information (PHI) – individually identifiable health information that is transmitted or maintained in any form or medium, including electronic media. Protected health information does not include employment records held by MSOC in its role as an employer.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

For Treatment. We will use your health information to provide you with health care treatment and to coordinate or manage services with other health care providers, including third parties. We may disclose all or any portion of your health information to your attending physician, consulting physician(s), nurses, technicians, health profession students, or other facility or health care personnel who have a legitimate need for such information in order to take care of you.

Different departments of the facility will share your health information in order to coordinate the health care services you need, such as prescriptions, lab work and X-rays. We may disclose your health information to family members or friends, guardians or personal representatives who are involved with your health care. We may also use and disclose your health information to contact you for appointment reminders and to provide you with information about possible treatment options or alternatives and other health-related benefits and services. We also may disclose your health information to people outside the facility who may be involved in your health care after you leave the facility, such as other physicians involved in your care, specialty hospitals, skilled nursing care facilities, and other healthcare-related services. We may use and disclose your health information to prescription networks to obtain your prescription benefits from payers, to obtain your medication history from different health care providers in the community such as pharmacies, and to send your prescriptions electronically to your pharmacy.

For Payment. We will use and disclose your health information for activities that are necessary to receive payment for our services, such as determining insurance coverage, billing, payment and collection, claims management, and medical data processing. For example, we may tell your health plan about a treatment you are planning in order to receive approval or to determine whether your plan will pay for the proposed treatment. We may disclose your health information to other health care providers so they can receive payment for health care services that they provided to you, such as your personal physician, and other physicians involved in your health care such as an anesthesiologist, pathologist, radiologist, or emergency physician, and ambulance services. We may also give information to other third parties or individuals who are responsible for payment for your health care, such as the named insured under the health policy who will receive an explanation of benefits (EOB) for all beneficiaries who are covered under the insured's plan.

For Health Care Operations. We may use and disclose your health information for routine facility operations, such as business planning and development, quality review of services provided, internal auditing, accreditation, certification, licensing or credentialing activities (including the licensing or credentialing activities of health care professionals), medical research and education for staff and students, assessing your satisfaction with our services, and to other healthcare entities that have a relationship with you and need the information for operational purposes. We may use and disclose your health information to the external agencies responsible for oversight of health care activities such as The Joint Commission, external quality assurance and peer review organizations, and credentialing organizations. We may also disclose health information to business associates we have contracted with to perform services for or on our behalf such as patient satisfaction survey organizations. We may also disclose your health information to medical device manufacturers or pharmaceutical companies in order for those companies to carry out their legal obligations to state and federal agencies.

Research. We may use and disclose your health information to researchers either when you authorize the use and disclosure of your health information, or an Institutional Review Board and/or Privacy Board approves an authorization waiver for the use and disclosure of your health information for a research study. A waiver may allow a researcher to use or disclose your health information to prepare for research, to screen and identify participants for inclusion in a research study, or to conduct research on a decedent's information.

Organ and Tissue Donation. If you are an organ donor, we may release your health information to organizations that handle organ procurement and transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

USES AND DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

Subject to requirements of federal, state and local laws, we are either required or permitted to report your health information for various purposes. Some of these reporting requirements and permissions include: Public Health Activities. We may disclose your health information to public health officials for activities such as for the prevention or control of communicable disease, bioterrorism, injury, or disability; to report births and deaths; to report suspected child, elder, or spouse abuse or neglect; to report reactions to medications or problems with medical products; to report information to the federal Centers for Disease Control or to authorized national or state cancer registries for their data aggregation.

Disaster Relief Efforts. We may disclose your health information to an entity assisting in a disaster relief effort, such as the American Red Cross, so that your family can be notified about your condition and location.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. Such agencies include federal Centers for Medicare and Medicaid Services, and state health professional oversight agencies or boards such as state medical or nursing boards. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor activities such as health care treatment and spending, government programs, and compliance with civil rights laws.

Judicial or Administrative Proceeding. We may disclose your health information in response to a legal court or administrative order, a subpoena, discovery request, civil or criminal proceedings, or other lawful process.

Law Enforcement. We may release your health information if asked to do so by a law enforcement official or if we have a legal obligation to notify the appropriate law enforcement or other agencies:

- In response to a court order, subpoena, warrant, summons or similar legal process;
- Regarding a victim or death of a victim of a crime in limited circumstances;
- In emergency circumstances to report a crime, the location or victims of a crime, or the identity, description or location of a person who is alleged to have committed a crime, including crimes that may occur at our facility, such as theft, drug diversion, or attempts to obtain drugs illegally.

Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or a medical examiner. This may be necessary to identify a person who died or to determine the cause of death. We may release health information to help a funeral director to carry out his/her duties.

Workers' Compensation. We may release your health information for workers' compensation benefits or similar programs that provide benefits for work-related injuries or illnesses if you tell us that workers' compensation is the payer for your visit(s). Your employer or their workers' compensation carrier may request the entire medical record pertinent to your workers' compensation claim. This medical record may include details regarding your health history, current medications you are taking, and treatments.

To Avert a Serious Threat to Health or Safety. We may disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public.

National Security. We may disclose your health information to federal official(s) for national security activities and for the protection of the President and other Heads of State.

Military and Veterans. If you are a member of the armed forces, we may release your health information as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Inmates. If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may release your health information to the institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

OTHER USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Other uses and disclosures of your health information not covered by this notice or the laws that apply to MSOC will be made only with your written authorization. If you provide us with authorization to use or disclose your health information, you may revoke that authorization in writing at any time. When we receive your written revocation we will no longer use or disclose your health information for the purpose of that authorization. However, we are unable to retrieve any disclosures already made based on your prior authorization.

MSOC will obtain your authorization to use and disclose your health information for these specific purposes when required by law and regulation:

Marketing. Marketing is a communication about a product or service that you may be interested in purchasing. If MSOC receives payment from a third party in order for MSOC to promote the product or service to you, then MSOC is required to obtain your written authorization before we can use or disclose your health information. MSOC is not required to obtain your authorization to discuss with you MSOC health care treatment options, health-related products, case management or care coordination, or to direct or recommend alternative treatments, therapies, providers, or settings of care, providing face to face discussions and offering samples or promotional gifts of nominal value. You have the right to revoke your marketing authorization and MSOC will honor the revocation. To opt out of these communications, please contact MSOC at (734) 434-3020 or in writing at 4972B W Clark Rd. Suite 200, Ypsilanti, MI 48197.

Sensitive Medical Information. We may obtain a separate authorization from you, when required by specific state and federal laws, to use or disclose sensitive medical information, such as psychiatric, substance abuse, infectious disease, or genetic testing information.

Sale of Health Information. MSOC will obtain your authorization for any disclosure of your health information which MSOC directly or indirectly receives remuneration in exchange for the health information.

THIS NOTICE DOES NOT APPLY TO THE FOLLOWING HEALTH RELATED ACTIVITES

Some activities of MSOC may not be covered by this notice. If you seek services at wellness or health fairs, for occupational health services, employee health related services, or direct access lab services this notice and its components do not apply.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information:

Right to Inspect and Copy. You have the right to inspect your health information and receive a copy of medical, billing, or other records that may be used to make decisions about your care. The right to inspect and receive a copy may not apply to psychotherapy notes that are maintained separately from your health information.

Your request to inspect and receive a copy of your health information must be submitted in writing. We may charge a fee for document requests to cover the costs of copying, mailing, or other supplies. You have the right to request your health information in electronic format. MSOC will provide your health information in the form and format you request, if feasible, or in a mutually agreeable form and format.

Submit your request in writing using our "Authorization for Use or Disclosure of Protected Health Information" form to the Health Information Management department or the custodian of the record at the specific clinic. For assistance call MSOC at (734) 434-3020.

In limited circumstances we may deny your request to inspect or receive a copy of your health information. If we deny your request we will notify you of the reason. If you are denied access to your health information, you may request that the denial be reviewed. A licensed health care professional chosen by MSOC will review your request and the denial. The person who conducts the review will not be the same person who denied your request. We will comply with the outcome of the review.

Right to Amend. You have the right to request an amendment to your health information that you believe is incorrect or incomplete.

Submit your request in writing, including your reason for the amendment, using our "Request for Amendment to PHI" form and send it to the Health Information Management department or the custodian of the record at the specific clinic. For assistance call MSOC at (734) 434-3020.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that:

- Was not created by MSOC unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for MSOC;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. We are required to maintain a list of certain disclosures of your health information. However, we are not required to maintain a list of disclosures that we made by acting upon your written authorizations. You have the right to request an accounting of disclosures that are not subject to your written authorization.

Submit your request in writing using our "Request for Accounting of Disclosures of PHI" form and send it to 4972B W Clark Rd. Suite 200, Ypsilanti, MI 48197. For assistance call MSOC at (734) 434-3020. Your request must state a time period, not longer than six years from the date of request. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on how much of your health information we use or disclose for treatment, payment, or health care operations. You also have the right to request a restriction on the disclosure of your health information to someone who is involved in your care or payment for your care, such as a family member or friend.

We are not required to agree to your request. However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

You have the right to request that we restrict the disclosure of your information to a health plan regarding a specific health care item or service that you, or someone on your behalf (other than a health plan), has paid for in full. We are required to comply with your request for this specific type of restriction. For example, if you sought counseling services and paid in full for the services rather than submitting the expenses to a health plan, you may request that your health information related to the counseling services not be disclosed to your health plan.

Submit your request in writing or request and submit a "Request for Restrictions to Use or Disclose Protected Health Information" form and send it to 4972B W Clark Rd. Suite 200, Ypsilanti, MI 48197. For assistance call MSOC at (734) 434-3020. You must include: a description of the information that you want to restrict, whether you want to restrict our use or disclosure or both; and to whom you want the restriction to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. For example, you can ask that we only contact you at an alternative location from your home address, such as work, or only contact you by mail instead of by phone. Your request must specify how or where you wish to be contacted. We do not require a reason for the request. We will accommodate all reasonable requests.

Right to Receive Notice of a Privacy Breach. You have the right to receive written notification if MSOC discovers a breach of unsecured protected health information involving your health information. Breach means the unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of the information. The Notice will include a description of the breach, health information involved, steps we have taken to mitigate the breach, and actions that you may need to take in response to the breach.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. If you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

To ask questions about any of these rights, or to obtain a paper copy of this notice, contact the MSOC offfice at (734) 434-3020 or in writing to 4972B W Clark Rd. Suite 200, Ypsilanti, MI 48197. Or, you may obtain a copy of this notice at our web site, www.michigansportsmedicine.com.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you and for any information we may receive in the future. We will post a copy of the current notice in the facility and on our web site (if applicable) at www.michigansportsmedicine.com. The notice will contain the effective date. Upon your initial registration or admittance to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the notice currently in effect. Whenever the notice is revised, it will be available to you upon request.

COMPLAINTS

You may file a complaint with us or with the Secretary of the Department of Health and Human Services if you believe that we have not complied with our privacy practices. You may file a complaint with us by contacting MSOC at (734) 434-3020 or in writing at 4972B W Clark Rd. Suite 200, Ypsilanti, MI 48197.

If you file a complaint, we will not take any action against you or change our treatment of you in any way.