

NORTHERN PINES

HEALTH CENTER, PC

11293 N M-37, Suite A - Buckley, MI 49620

Phone (231) 269-4185 - Fax (231) 269-4461

Dear New Patient:

We would like to take a moment to personally welcome you to our practice. We are pleased that you have chosen our provider, _____ to be your primary care provider. We are a full spectrum primary care medical office and received Patient Centered Medical Home (PCMH) designation in 2013. Northern Pines Health Center is committed to providing compassionate, high-quality healthcare, while stressing prevention and health education for patients of all ages.

We offer many services including: personalized care management, preventative care, well/preventative exams, immunizations, immigration physicals, chronic health maintenance, acute illness care, respiratory services, and minor office procedures. Other services offered on-site include: Munson Medical Center Laboratory and Dynamic Physical Therapy. Northern Pines Health Center also has a clinical research division with research professionals who have been conducting clinical research studies since 2006.

Our office is open Monday through Friday from 7:30AM to 5:00PM. To schedule an appointment, call our main number (231) 269-4185. We offer walk-in hours daily from 11:00AM to 11:45AM and from 4:00PM to 4:45PM for your acute needs.

If you need to reach a provider after hours, you may contact our After-Hours Service at (231) 261-8934 and ask for the provider on call. It is our policy that prescriptions will not be prescribed or refilled over the phone.

The following documents are enclosed for your review. Please sign the documents and return them upon check-in for your first appointment.

- Personal Health Information Release
- Authorization for Release of Health Information
- Patient Portal Authorization Form
- Patient Portal Proxy Access Form (required if you are requesting access to a portal other than your own)

The following documents are enclosed for your review. You will sign these documents electronically in our office upon check-in for your first appointment and annually thereafter.

- Notice of Privacy Practices
- Consent for Treatment/ Financial Authorization
- Financial Policy

Prior to your first visit please notify your insurance company of your new primary care provider. We ask that you bring the completed forms, insurance card(s), picture identification and all your medications with you to your initial appointment.

If you have any questions or need to reschedule your appointment please contact our office. We do require 24-hour notice if you are unable to keep a scheduled appointment. Three missed appointments (and/or appointments that are canceled without 24-hour notice) will result in dismissal from the practice.

Thank you for choosing Northern Pines Health Center for your primary care needs.



Personal Health Information Release

Northern Pines Health Center adheres to a strict policy of not releasing protected health information to individuals other than the patient. **By indicating below, you can designate others to receive your health information.**

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral mental services, and treatment for alcohol and drug abuse.

I authorize Northern Pines Health Center to release protected health care information about myself to the following individuals:

Name _____ Relation _____ Phone # _____

Name _____ Relation _____ Phone # _____

Name _____ Relation _____ Phone # _____

Name _____ Relation _____ Phone # _____

By indicating below, **you may also elect to receive messages with more detailed information than the standard allows.**

I authorize Northern Pines Health Center to leave detailed messages (i.e. test results, returned messages, etc.) relating to my medical information on my answering machine at the telephone numbers listed below. I do specifically consent to receive telephone calls, short messages ("SMS") text messages or other messages made or delivered to the telephone number(s) I provide to Northern Pines Health Center. I acknowledge that these calls may be made or delivered using an automatic dialing system and/or artificial or pre-recorded voice made by Northern Pines Health Center or its business associates for purposes of treatment, payment, and healthcare options:

Initial _____ Phone Number _____

Initial _____ Phone Number _____

I hereby grant the above elected methods of communicating my protected health information. Furthermore, I understand that I may change or rescind my elections either by completing a new form, or by written correspondence with this office; otherwise, this election remains valid and in effect indefinitely.

Patient or Legal Representative Signature _____ Date: _____

Patient Name: _____ Date of Birth: _____



Authorization for Release of Health Information

Please complete all sections below.

SECTION 1: Patient Information (Please Print)

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH (MM/DD/YY)
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS	

SECTION 2: Specific Health information to be released or disclosed:

<input type="checkbox"/> All Health Information	<input type="checkbox"/> EKG/Cardiology Reports	<input type="checkbox"/> Diagnostic Test Reports	<input type="checkbox"/> Operation Reports
<input type="checkbox"/> Physician's Orders	<input type="checkbox"/> History/Physical Exam	<input type="checkbox"/> Past/Present Medications	<input type="checkbox"/> Lab Results
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Patient Allergies	<input type="checkbox"/> Billing Information
<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Radiology Reports & Images	<input type="checkbox"/> Other _____

- **Limited Dates of Service:** _____ **If initialed here,** I authorize the Practice to disclose the above health information ONLY for the following dates of service: ____/____/____ to ____/____/____.

SECTION 3: What Provider/Facility should the health information be requested FROM:

- Northern Pines Health Center – 11293 N M-37 Suite A, Buckley, MI 49620 Phone:231-269-4185 Fax: 231-269-4461
- Name, Address, Phone of Provider/Facility: _____

SECTION 4: To whom is the requested Protected Health Information being released TO: (Select One)

- Northern Pines Health Center – 11293 N M-37 Suite A, Buckley, MI 49620 Phone:231-269-4185 Fax: 231-269-4461
- Mitzie Hewitt, DO Sydney Steger, PA-C Christina Peltier, NP Macie White, PA-C
- Myself – Paper copy via US Mail to address in Section 1
- Other: I am the patient, or the legally authorized representative of the patient listed in Section 1 and request the protected Health Information as indicated on this form to be released to:

Individual/ Person Name		Company/Organization	
Street Address			
City	State	Zip	Phone Number

SECTION 5: Select Delivery Method for Protected Health Information

- Paper Copy via US Mail to other Address: _____
- Email (PDF)
- Fax #: _____
- Other Electronic Type (must be specific): _____

These records to include, if any, alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA); social services records; and psychological services records, including communications made by me to a social worker or psychologist and all information defined by statute and Michigan Department of Public Health Rules (Public Act 174,1989) governing HIV, HIV Test, Acquired Immunodeficiency Syndrome (AIDS) and AIDS-related complex (ARC), as well as genetic and demographic information for the purposes and conditions designated within this document.

SECTION 6: Purpose of Request/Disclosure:

- Personal Use
- Other (Please Specify): _____

SECTION 7: Signature of Patient or Patient Representative

By signing this authorization, I consent to the disclosure of the information as stated within this document. I understand and agree to the following:

- I will not hold Northern Pines Health Center liable for any misrepresentation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation.
- I understand that failure to provide all information requested may invalidate this authorization.
- I understand that I may refuse to sign this Authorization and that my health care cannot be conditioned upon signing this Authorization.
- I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.

This Authorization will expire one year from date of signing or otherwise by my choice, in which case this consent will expire on the date of ____/____/____.

Patient or Legal Representative Signature **Date** **Time**

Legal Representative Relationship to Patient

- If patient is a minor or incapable of signing, a copy of appropriate legal documentation is attached, if applicable.

Witness Signature **Date** **Time**

This Authorization is subject to a written revocation (cancelling) at any time except in those circumstances in which Northern Pines Health Center has taken certain actions in reliance on such Authorization. However, this Authorization shall be valid no longer than it is reasonably necessary to accomplish the purpose of the actions for which it was given.

REVOCATION (OPTIONAL) – This Authorization is revoked for the following specified dates, events, or conditions.

DATE: ____/____/____ **EVENT:** _____ **CONDITION:** _____

Authorization must be dated subsequent to the service that you are requesting except in cases of ongoing treatments.

IDENTITY VERIFIED BY:		
NAME:	POSITION:	DATE:
INFORMATION RELEASED BY:		
NAME:	POSITION:	DATE:



Patient Portal Authorization Form

Northern Pines Health Center, P.C. provides a patient portal for the exclusive use of its established patients. The patient portal is designed to enhance patient-provider communications. Once you are registered as a patient and have provided us with your secure email you will be assigned a username and password. After you register with the patient portal you will have the ability to:

- Submit medication refill requests
- Access and review health education materials
- Communication of laboratory results
- Update profile and contact information
- Review and download personal health information

NEVER USE THE PATIENT PORTAL FOR URGENT OR EMERGENCY MEDICAL EMERGENCIES. In an emergency, call 911. It may take 72 hours or 3 business days to receive a response to an email request. If you do not receive a response within 72 hours or 3 business days you should contact the office at (231) 269-4185.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Instructions for Accessing the Patient Portal:

Bring this completed and signed form to our office. Once our office receives this form an email containing your username and temporary password will be sent to the email address provided by you. **Your temporary password is only active for 24 hours. If you do not access the portal within 24 hours you will have to obtain a new password by calling or visiting our office.**

You may access the patient portal by typing the following webpage address into your browser: www.northernpineshealthcenter.com and clicking the last tab at the top of the page titled, "PATIENT PORTAL". After clicking on this tab, in the middle of the page you will see a hyperlink titled, "ACCESS YOUR PATIENT PORTAL" click on this hyperlink and you will be directed to the Patient Portal login page. Enter your login information. You will then be asked to read and accept the terms and conditions of, "Northern Pines Health Center's Patient Portal Participation Agreement". After you have

accepted the terms and conditions, you will be instructed to set up a security question and change your password. Your temporary password is only active for 24 hours

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1. The secure message must reach the correct email address, and
2. Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct email address and that you inform us of any changes to your email address.**

You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and policies and procedures regarding the patient portal that appears at log in. I understand the risks associated with online communication between my healthcare provider and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the policies and procedures set forth in the log in screen, as well as any other instructions that my healthcare provider may impose to communicate with patients via online communications. I understand that participation is voluntary and I may terminate participation at any time by contacting the office either in person or in writing. I understand and agree with the information that has been provided.

- I opt-out of the patient portal and therefore do not have access to my health information online. I understand I can revoke my declination and opt-in at any time by informing the front office staff.

Secure Email Address: _____

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

This form must accompany a completed and signed, "Patient Portal Proxy Access Form" before portal access will be given to anyone other than the patient (this includes minor children).



Patient Portal Proxy Access Form

1. Patient Information

Patient Name: _____ Patient Date of Birth: _____

2. Proxy Information: (Person to who you authorize Northern Pines Health Center, P.C. to release the Patient Portal Record)

Proxy Name: _____ Proxy Date of Birth: _____

Proxy Email Address: _____

<u>Adult Patient</u>	<u>Minor Patient</u>
<p>Access to another adult's Patient Portal record.</p> <p>Select One:</p> <p><input type="checkbox"/> Adult Patient</p> <ul style="list-style-type: none"> The patient should sign this form to provide authorization for release of their medical information. Authorization for proxy access is valid until revoked by patient. <p><input type="checkbox"/> Legal Representative of Adult Patient: (Adults who have a surrogate relationship with another adult through a legal arrangement)</p> <p>Select the option below that best describes the relationship:</p> <p style="padding-left: 40px;"><input type="checkbox"/> Legal Guardian (court order)</p> <p style="padding-left: 40px;"><input type="checkbox"/> DPOA for Health Care</p> <ul style="list-style-type: none"> If you are a legal guardian or you have a durable power of attorney for healthcare for this patient, then this request must be verified by the legal paper work confirming your authority to have access to the patient's medical information. You must notify the hospital immediately in case of any change in authority. 	<p>Access to your minor child's Patient Portal record.</p> <p>(Note: Individuals requesting access must have parental rights or legal guardianship rights.)</p> <p>My relationship to the child is:</p> <p><input type="checkbox"/> Parent</p> <p><input type="checkbox"/> Permanent Legal Guardian of the Patient-must verify the Court Order Appointing Guardian and letters of Guardianship confirming the Proxy's status as permanent legal guardian of the patient.</p> <p>Select One:</p> <p><input type="checkbox"/> Patient Age 0-12: You will be granted access to your child's portal until the child turns 13 years old.</p> <p><input type="checkbox"/> Patient Age 13-17: You will be granted access to your teenage child's portal if your child signs an authorization form.</p> <ul style="list-style-type: none"> Authorization for proxy access is valid until revoked by parent/permanent legal guardian or child.

Authorization:

- By signing this proxy request, I understand that I am giving my permission for Northern Pines Health Center to disclose my protected health information (PHI) through the Patient Portal to my proxy. Information includes, but is not limited to: current medications, visit summaries and lab results.
- I am fully aware that the username and password may be sent to the email address indicated above and whomever has access to that email has access to the username and password sent by Northern Pines Health Center to access my protected health information through the patient portal.
- The information available to my proxy may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, (2) treatment for drug or alcohol abuse, (3) sexually transmitted diseases, (4) mental or behavioral health or psychiatric care, or (5) reproductive/pregnancy services.
- This proxy request includes records that were created or existing on or before the date this form was signed, as well as records that are created after the date this form is signed.
- I understand that I have a right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing. I understand that such a revocation will not have any effect on any information already released to my proxy.
- I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Michigan State privacy laws.
- I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment. If I refuse to sign this authorization, access to my Patient Portal account will not be granted.

By signing below, parents acknowledge and agree that:

- I have parental rights or legal guardianship rights to access this Child's record.
- I have not been denied periods of physical placement with the Child and there are no court orders or restraining orders in effect limiting my access to this Child's medical records and/or information.
- Communications on behalf of the Child through the Patient Portal must be sent from the Child's record and responses will be received in the Child's record.
- For a child age 0-12 years, I will be granted full access to the Child's Patient Portal record. At the age of 13, the child must authorize me to access it.

Legal Representatives:

- Any documents I have provided in support of my right to access the patient's protected health information, are true and correct copies and are the most recent documents related to this matter. When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated, or expired, I must immediately notify Northern Pines Health Center in writing of the change in authority.

By signing below, I acknowledge and agree that:

- I will comply with the terms and conditions on the Portal Participation Agreement page and this document.
- I will be provided with a username and password to access the portal either in person, standard USPS mail at the most recent address provided by me or in an email which will be sent to the email address indicated under "Proxy Email Address" above.
- I have received education pertaining to the Patient Portal and I have had a chance to ask questions and receive answers.
- I understand that the email address provided under "Proxy Email Address" will be used for communications regarding the patient portal which may include, but is not limited to receiving emails containing login information necessary to access my personal health information. I understand and accept that it is my responsibility to keep the email provided under "Proxy Email Address" secure from unauthorized persons.

X _____
Patient Signature*

Date

X _____
Parent or Legal Representative Signature*

Date

*Patient or Legal Representative must sign if patient is 13 or older. Parent may only sign if patient is age 0-12.



NORTHERN PINES HEALTH CENTER CONSENT FORMS

FINANCIAL POLICY

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. Your clear understanding of our "Financial Policy" is important to our professional relationship. Please ask if you have any questions about our fees, our policies or your responsibilities.

Usual and Customary

Our charges are usual and customary for our area. Charges are determined from universal numeric codes assigned by your healthcare provider in accordance with strict Federal and State billing guidelines governing code selection. These numeric codes describe the intensity of the exam and the medical decision-making required for your care. Charges for services rendered may vary from visit to visit depending on the level of care rendered by your healthcare provider.

Payment at Time of Service

All known patient responsible charge balances, such as outstanding balances, non-covered services, coinsurances, co-payments and deductibles, will be collected upon check-in. If you are unable to pay the charges you're responsible for in full, you may be asked to reschedule your appointment or referred to a local urgent care, emergency room or local free clinic except in the case of a medical emergency. We accept cash, personal check, Visa, MasterCard, Discover or American Express.

Insurance

It is your responsibility to provide the clinic with current insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. To assure accurate processing of services, we need your assistance in providing insurance carrier information to us. Please be prepared to present your insurance card at every visit. Your insurance card and driver's license will be requested to be scanned into our practice management system.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Our staff is unaware of your individual insurance benefits. It is your responsibility to know if a certain service is not covered, please contact your insurance company.

As a courtesy, we will file your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. **You are ultimately responsible for the timely payment of your account.**

We participate with many insurance companies. Participation means that we have a contract with these insurance companies and must accept their "allowable" fee as reimbursement in full (deductibles, copays, co-insurances and non-covered services are not included). **If we DO participate with your insurance company and we are able to verify your insurance**, all services performed in our office will be submitted to them, unless we have received prior notification of non-covered services. All copays and deductibles are the patient's responsibility and are due at the time of service.

If we do not participate with your insurance company or if we are unable to verify your insurance, payment in full is expected prior to services being rendered. In such instances, we will file the insurance claim and accept the payment, but we will not accept the contractual adjustment. That balance will be the patient's responsibility and any balances that are not covered will be the patient's responsibility. If you are unsure if we participate with your insurance plan, please check with your own insurance company or employer to ask about participation prior to receiving any services. Participation is subject to change.

Some insurances require you to designate a PCP and seek care at your designated PCP's office. **If we are not designated as your PCP and this is a requirement of your insurance company, you will likely be responsible for the entire charge.** If you are unsure whether a provider at our office is designated as your PCP or if this is a requirement of your insurance company, you should contact your insurance company prior to receiving services in our office.

Patients with NO Medical Insurance

If you do not have insurance, payment for professional services is expected at the time of service. You are expected to notify the registration specialist, upon check-in, of your payment method. Patients with no insurance receive a 25% discount off physician services (excluded services, include but are not limited to, immunizations, DOT physicals, sports physicals, travel physicals, immigration physicals, injections, lab services, form fees, returned check fees and procedures. The discount does not apply to referred care, such as outpatient laboratory services, x-ray, diagnostic tests, etc.). To receive this discount the balance must be paid in its entirety on the same date services are rendered.

Minor Patients

The adult accompanying a minor (parent or legal guardian of the minor) is responsible for payment in full. For unaccompanied minors, non-emergency treatment may be denied unless payment or payment arrangements have been made in advance. To comply with state and federal regulations, any patient 18 or older will be held legally and financially responsible and will receive their own billing statement regardless of the insurance policy holder.

Returned Checks

The charge for a returned check is \$30 payable by cash or money order. This charge will be applied to your account. You will be placed on a "Cash-Only" basis following any returned checks.

Scheduled Medications

Scheduled medication and non-life-threatening medications will not be refilled until your account balance with us is paid in full.

Delinquent Accounts

Accounts that become delinquent will be subject to collection activity. If no payment has been made on your account after 120 days, you and your immediate family (immediate family is defined as all patients residing at the patient's address whose account is delinquent) will be discharged from the practice and your account will be turned over to a third-party collection agency.

Care Management

Northern Pines Health Center Patients with uncontrolled chronic or complex health concerns are required to participate in our care management program. Our care management program is based on a team approach between you, your provider and a registered nurse in our office to provide & coordinate an individual plan to meet specified health goals. There may be an out-of-pocket cost for these services dependent on your individual insurance plan, please contact your insurance to determine any cost responsibilities.

CONSENT FOR TREATMENT/FINANCIAL AUTHORIZATION

1. I hereby voluntarily request, consent to and authorize the physician, his/her associates, assistants or other practitioners to provide medical and minor surgical treatment, including but not limited to diagnostic procedures, x-rays, medication administration, physical examination and screening services, including drug/alcohol screening, smoking cessation education, as deemed necessary and advisable. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examination and treatment which I have hereby authorized.
2. I authorize Northern Pines Health Center, P.C. to release any third party payer, or its representative, including Medicare, Medicaid, Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, workers' disability compensation insurers, employers, health maintenance organizations, preferred provider organizations and managed care plans, which may be responsible for payment in my case, or a required by law, such information from my medical record as is necessary in order to receive reimbursement for any billings rendered relating to my treatment, including alcohol and drug abuse records protected under the regulations in 42 CFR, Part 2, if any, and social services records, if any, and psychological service records including communications by me to a social worker or psychologist. I also authorize Northern Pines Health Center, P.C. and its affiliates to release to individuals or agencies which may provide services for my care such information from my medical record as is necessary to provide those services. I also authorize the release of information to any independent auditors or reviewers retained by any third-party payer, private health insurers, or any employer providing health insurance benefits to me so that these independent auditors can analyze charges.
3. I further understand that my treatment may require more than one date of service, therefore this consent shall carry full force and effect from the date of signature until I am discharged from treatment.
4. I hereby assign payment directly to Northern Pines Health Center, P.C. of the insurance benefits otherwise payable to me but not to exceed the balance due to Northern Pines Health Center, P.C. for charges for these services.
5. I assume full financial responsibility for payment of all services provided to me, including any portion of my bill that is not paid by insurance, workers' disability compensation or social agencies.
6. I understand the content and significance of this form, and my questions have been answered.

****NOTICE****

If another person has a percutaneous, mucous membrane, or open wound exposure to my blood or other body fluids, Northern Pines Health Center, P.C. may perform, but not be limited to, the following tests: an HIV, hepatitis screens, and other blood borne pathogen tests, as needed, without any additional consent. Public Act No. 488 of 1988 of the State of Michigan states that an HIV test may be performed upon me without any additional consent, if a health professional or employee has a percutaneous, mucous membrane, or open wound exposure to my blood or other body fluids.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received Northern Pines Health Center, P.C.'s Notice of Privacy Practices.

By signing below, I am giving my consent to Northern Pines Health Center's Financial Policy, Consent for Treatment/Financial Authorization and Privacy Practices.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

11293 N M-37, Suite A - Buckley, MI 49620

Phone (231) 269-4185 - Fax (231) 269-4461

Privacy Officer: Keisha Sexton

Notice of Privacy Practices

Effective Date: August 1, 2004

Reviewed & Updated: September 30, 2016

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information ("protected health information" is referred to herein as "PHI"), to provide individuals with notice of our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. This notice describes how we may use and disclose your PHI. It also describes your rights and our legal obligations with respect to your PHI. If you have any questions about this Notice, please contact our Privacy Officer at (231) 269-4185.

1. How Northern Pines Health Center May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart [and on a computer] [and in an electronic health record/personal health record]. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

- A. **Treatment:** We may use and disclose your PHI in the provision and coordination of health care to carry out treatment functions. We may disclose all or any portion of your patient medical record information to your consulting physician(s), nurses, pharmacists, technicians, medical students and other health care providers who have legitimate need for such information in your care and continued treatment. Different departments will share PHI about you in order to coordinate specific services, such as lab work, x-rays, and prescriptions. We may also disclose your PHI to people or entities outside Northern Pines Health Center who will be involved in your medical care after you leave Northern Pines Health Center, such as other care providers who will provide services that are part of your care. We may share certain information such as your name, address, employment, insurance carrier, emergency contact information and appointment scheduling information in an effort to coordinate your treatment with us and with other health care providers. We may use and disclose your PHI to inform you of, or recommend possible treatment options or alternatives that may be of interest to you. We will use and disclose PHI to contact you as a reminder that you have an appointment for medical care at

Northern Pines Health Center. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

- B. Payment:** We may disclose PHI about you for the purposes of determining coverage, eligibility, funding, billing, claims management, medical data processing, stop loss / reinsurance and reimbursement. The PHI may be disclosed to an insurance company, third party payer, third party administrator, health plan or other health care provider (or their duly authorized representatives) involved in the payment of your medical bill and will include copies or excerpts of your medical records which are necessary for payment of your account. It will also include sharing the necessary information to obtain pre-approval of payment for your treatment from your health plan.

We may disclose PHI to collection agencies and other sub-contractors engaged in obtaining payment for care.

- C. Health Care Operations:** We may use and disclose PHI about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your PHI with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share PHI about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

- D. Other Uses and Disclosures:** As part of treatment, payment and health care operations, we may also use your PHI for the following purposes:

Medical Research: We may disclose your PHI without your authorization to medical researchers who request it for approved medical research projects; however, with very limited exceptions such as disclosures must be cleared through a special approval process before any PHI is disclosed to the researchers. Researchers will be required to safeguard the PHI they receive.

Information and Health Promotion Activities: We may use and disclose some of your PHI for certain health promotion activities. For example, your name and address will be used to send you newsletters or general communications. We will also send you information based on your own health concerns. We may send you this information if it has determined that a product or service may help you. The communication will explain how the product or service relates to your well-being and can improve your health.

- E. More Stringent State and Federal Laws:** The State law of Michigan is more stringent than HIPAA in several areas. State law is more stringent when the individual is entitled to greater access to records than under HIPAA and when under state law the records are more protected from disclosure than under HIPAA. Certain federal laws also are more stringent

than HIPAA. We will continue to abide by these more stringent state and federal laws. The federal laws include applicable internet privacy laws, such as the Children's Online Privacy Act and the federal laws and regulations governing the confidentiality of health information regarding substance abuse treatment. In Michigan patients have more rights of access to behavioral health information than under HIPAA and the state law defines a minimum necessary standard for release of mental health information. Disclosure is permitted with consent and for treatment without consent but only in an emergency. Minors in Michigan have more rights to confidentiality and protection of certain information (reproductive health, behavioral health, and substance abuse) than under HIPAA. State law requires facilities to adopt policies regarding release of information outside the facility. Our policy requires consent for release. State law genetic and HIV testing and disclosure consents remain in place.

II. Permitted Use or Disclosure with an Opportunity for You to Agree or Object

- A. **Notification and Communication with Family:** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are unable to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
- B. **Promotional Communications:** Northern Pines Health Center does not share or sell your PHI to companies that market health care products or services directly to consumers for use by those companies to contact you, such as drug companies. Northern Pines Health Center does maintain a database of individuals for promotional communications, disease management, and health promotion purposes. We send information to the individuals in this database about the programs and services of Northern Pines Health Center. If you wish to be deleted from this database, you may notify the Privacy Officer.
- C. **Proof of Immunization:** We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or dependent.

III. Use of Disclosure Requiring Your Authorization

- A. **Marketing:** Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your PHI for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
- B. **Fundraising:** We will not disclose your information for fundraising purposes.

- C. **Research:** We may use or disclose your PHI as part of research that includes providing you with treatment. For example, if you are part of a research study that includes treatment, Northern Pines Health Center may require that you sign an authorization to allow the researchers to use or disclose your PHI for this research.
- D. **Psychotherapy Notes:** We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to your health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
- E. **Other Uses:** Any uses or disclosures that are not for treatment, payment, or operations and that are not permitted or required for public policy purposes or by law will be made only with your written authorization. Written authorizations will let you know why we are using your PHI. You have the right to revoke an authorization at any time, except to the extent that we have taken action in reliance on the authorization.

IV. **Use of Disclosure Permitted by Public Policy or Law without your Authorization**

As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities. We will report drug diversion and information related to fraudulent prescription activity to law enforcement and regulatory agencies.

A. Law Enforcement Purposes: We may and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

B. Public Health & Safety: We may and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require information from a personal representative we believe is responsible for the abuse or harm.

In compliance with the requirements of the Michigan Department of Commerce, we will use and disclose PHI to avert a serious threat to health and safety of a person or the public. We will use and disclose PHI to Public Health Agencies for immunizations, communicable diseases, etc. We will use and disclose PHI for activities related to the quality, safety or effectiveness of FDA-regulated products or activities, including collecting and reporting adverse events, tracking and facilitating product recalls, etc. and post marketing surveillance. Any patient receiving a medical device subject to FDA tracking requirements may refuse to disclose, or refuse permission to disclose, their name, address, telephone number and social security number, or other identifying information for the purpose of tracking. We may and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

C. Health Oversight Activities: We may and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure, and other proceedings, subject to the limitations imposed by law.

D. Judicial and Administrative Proceedings: We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

E. Coroners, Medical Examiner, Funeral Directors: We will disclose your information to a coroner or medical examiner. For example, this will be necessary to identify a deceased person or to determine a cause of death. We will also disclose your PHI to funeral directors as necessary to carry out their duties.

F. Organ Procurement: We will disclose your information to an organ procurement organization or entity for organ, eye or tissue donation purposes when donation has been authorized or to verify that appropriate organ procurement procedures were followed.

G. Specialized Government Functions: We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

H. Workers' Compensation: We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

V. **Your Health Information Rights**

Although we at Northern Pines Health Center must maintain all records concerning your treatment by Northern Pines Health Center, you have the following rights concerning your PHI:

A. Right to Inspect and Copy: You have the right inspect and copy your health information except for: psychotherapy notes (those notes kept in a personal file by a therapist or physician and not part of the formal medical record), information that may be used in anticipation of, or that will be used in a civil, criminal, or administrative action or proceeding, and where prohibited or protected by law. We will deny your request for access to your PHI without giving you the opportunity to review that decision if: you don't have the right to inspect the information; or it is otherwise prohibited or protected by law; you are an inmate at a correctional institution and obtaining a copy of the information would risk the health, safety, security, custody or rehabilitation of you or other inmates; the disclosure of the information would threaten the safety of any officer, employee or other person at the correctional institution or who is responsible for transporting you; you are involved in a clinical research project and Northern Pines Health Center created or obtained the PHI during that research. Your access to the information will be temporarily suspended for as long as the research is in progress; we obtained the information that you seek access to from someone other than the health care provider under a promise of confidentiality and your access request is likely to reveal the source of the information; or under other limited circumstances. In these instances, however, Northern Pines Health Center will allow the review of its decision by a health care professional that Northern Pines Health Center has chosen. This person will not have been involved in the original decision to deny your request. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the

right to have them transferred to another mental health professional. To access your PHI, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We will respond to your request within 30 days of its receipt. If we cannot, we will notify you in writing to explain the delay and the date by which we will act on your request. In any event, we will act on your request within 60 days.

- B. **Right to Amend or Supplement:** You have the right to request that we amend your PHI that you believe is incorrect or incomplete. However, we will deny your request for amendment if: Northern Pines Health Center did not create the information (unless the person or entity that created the information is no longer available to make the amendment); the information is not part of the designated record set; the information would not be available for your inspection (due to its condition or nature); the information is accurate and complete; we do not have the information; or if you would not be permitted to inspect or copy the information at issue. You must make your request for amendment of your PHI in writing to Northern Pines Health Center, including your reason(s) you believe the information is incorrect or incomplete. We will respond to your request within 60 days of its receipt. If we cannot, we will notify you in writing to explain the delay and the date by which we will act on your request. In any event, we will act on your request within 90 days of its receipt. We are not required to change your health information. If we deny your request for changes in your PHI, we will notify you in writing with the reason for the denial. We will also inform you of your right to submit a written statement disagreeing with the denial. You may ask that we include your request for amendment and the denial any time that Northern Pines Health Center discloses the information that you wanted changed. We may prepare a rebuttal to your statement of disagreement and will provide you with a copy of that rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
- C. **Right to an Accounting:** You have a right to receive an accounting of the disclosures of your PHI that Northern Pines Health Center made, except for the following disclosures: to carry out treatment, payment or health care operations; to you; to persons involved in your care; for national security or intelligence purposes; to correctional institutions or law enforcement officials; or that occurred prior to April 14, 2003. For each disclosure, you will receive: the date of the disclosure, the name of the receiving organization and address (if known), a brief description of the PHI disclosed and a brief statement of the purpose of the disclosure or a copy of the written request for the information, if there was one. You must make your request for an accounting of disclosures of your PHI in writing to Northern Pines Health Center. You must include the time period of the accounting, which may not be longer than 6 years. We will respond to your request within 60 days from its receipt. If we cannot, we will notify you in writing to explain the delay and the date by which we will act on your request. In any event we will act on your request within 90 days of its receipt. In any given 12-month period, we will provide you with an accounting of the disclosures of your PHI at no charge. Any additional requests for an accounting within that time period will be subject to a reasonable fee for preparing the accounting.
- D. **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of your PHI: to carry out treatment, payment or health care operations functions; or restricting specific information to only specified family members, relatives, close personal friends or other individuals involved in your care. For example, you may ask

that your name not be used in the waiting room or that information about your condition not be shared with your family. We will consider your request but are not required to agree to the requested restrictions.

- E. **Right to Confidential Communications:** You have the right to receive confidential communications of your PHI by alternative means or at alternative locations. For example, you may request that we only contact you at work or by mail. We will make every attempt to honor your request, but we reserve the right to deny unreasonable requests. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
- F. **Right to a Paper or Electronic Copy of this Notice:** You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.
- G. **Right to Request Special Privacy Protections:** You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of pocket, we will abide by your request unless we must disclose the information for treatment or legal reasons, We reserve the right to accept or reject any other request, and will notify you of our decision.
- H. **Breach Notifications:** In the case of a breach of unsecured protected health information, we will notify you as required by law.
If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer at (231) 269-4185.

VI. Complaints

If you believe your privacy rights have been violated, you may file a complaint with Northern Pines Health Center or with the Secretary of the Department of Health and Human Services. To file a complaint with Northern Pines Health Center, please contact Northern Pines Health Center's Privacy Officer at:

11293 N M-37 Suite A
Buckley, MI 49620
(231) 269-4185

All complaints must be submitted in writing to the Privacy Officer. Northern Pines Health Center assures you there will be no retaliation for filing a complaint.

VII. Sharing and joint use of your Health Information

In the course of providing care to you and in furtherance of our mission to improve the health of the community, we will share your PHI with other organizations as described below who have agreed to abide by the terms described below:

- A. **Medical Staff:** The medical staff and Northern Pines Health Center participate together in an organized health care arrangement to deliver health care to you. Northern Pines Health Center and its medical staff have agreed to abide by the terms of this Notice with respect to PHI created or received as part of the delivery of health care services to you at Northern Pines Health Center. Physicians and allied health care providers are members of Northern Pines Health Center's medical staff and will have access to and use your PHI for treatment, payment and health care operations purposes related to your care within Northern Pines Health Center. Northern Pines Health Center will disclose your PHI to the medical staff for payment, treatment and health care operations.

- B. Business Associates:** We will use and disclose your PHI to business associates contracted to perform business functions or its affiliate, Munson Healthcare. Whenever an arrangement between Northern Pines Health Center and another company involves the use or disclosure of your PHI, that business associate will be required to keep your information confidential.

VIII. Additional Information

For further information regarding the subjects covered in this Notice of Privacy Practice, please contact Northern Pines Health Center's Privacy Official at (231) 269-4185.

IX. Changes to this Notice

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our lobby and reception area, and a copy will be available at each appointment.

X. Change of Ownership

In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.