HIPAA Notice of Privacy Practices

Tri-State Mountain Neurology Associates, P.C.
1321 Sunset Drive
Suite 11
Johnson City, Tennessee 37604
(423) 928-6174

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that they physician has the necessary information to diagnose to treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

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

We may use or disclose your protected health information in the following situations without authorization. These situation include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosers to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

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

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

- You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

  Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

- You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

- You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may file a complaint with us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint.

This notice was published and becomes effective on/or before **April 14, 2003**

Tri-State Mountain Neurology Associates

Chart # _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICIES

I have been provided with a personal copy of the Notice of Privacy Practices from Tri-State Mountain Neurology Associates detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information.

Signed: ✕ _____ Date: _____

PATIENT AUTHORIZATION REGARDING CONTACT METHODS

We want to know how to get medical information to you if we are unsuccessful in reaching you at your home phone. By placing your initials in the spaces below you give your authorization to have your information relayed to you as follows:

X _____ (Initial here) You may contact me at work. The phone number is _____

X _____ (Initial here) You may leave messages on my answering machine. _____

X _____ (Initial here) You may call me on my cellular phone. The number is _____

You may also leave messages with my spouse and/or relative(s) and/or friends listed below.

✓ _____ (Name of Person) _____ (Phone Number) _____ (Relationship to patient)

✓ _____ (Name of Person) _____ (Phone Number) _____ (Relationship to patient)

✓ _____ (Name of Person) _____ (Phone Number) _____ (Relationship to patient)

I hereby release Tri-State Mountain Neurology Associates, P.C. from any and all liability that may arise from the release of the information given or obtained using the methods above.

Signed: ✕ _____ Date: _____

Tri-State Mountain Neurology Associates

Pain and Controlled Substance Policy and Patient Agreement

Patient Name: _____ Chart #: _____

Treatment involving pain and other controlled medications requires close supervision. State and Federal laws demand careful administration of such medications. Due to addiction potential and legal issues involved, management of medicines for pain will be done under the guidelines listed below. This agreement is to prevent misunderstanding about certain medicines sometimes used for pain management and will help us all to comply with the law regarding controlled pharmaceuticals.

I, the above named patient, understand and agree as follows:

1. I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship; and that my doctor undertakes to treat me based on this agreement.
2. I understand that if I break this agreement, my doctor will stop prescribing all controlled medicines and may terminate treatment.
3. I agree to communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, how well the medicine is helping to relieve the pain and how specifically I am using my medication(s). Family conferences may be undertaken at the discretion of my doctor to clarify such issues.
4. I understand and agree that my medicine **must** last the specified number of days. Therefore, I agree not to alter the way in which my medication(s) are taken without permission from the clinic. I further understand that my pain medication(s) are to be used only for the condition for which they are prescribed, e.g., do not use pain medication given for nerve injury for fracture or dental pain.
5. I understand that controlled medicine (including refills) will **NOT** be phoned or faxed to a pharmacy. Scripts must be picked up at the clinic. No controlled medications will be refilled after hours or on weekends. **If I miss an appointment, I understand that pain and other controlled medications will not be refilled until I keep the next appointment.**
6. I agree to safeguard my pain medication against theft or loss. I understand that my doctor will NOT refill prescriptions which have been lost, misplaced or stolen.
7. I agree not to use any illegal substances such as, but not limited to, marijuana, cocaine, methamphetamine, etc., and if asked I will submit to drug screens and pill counts.
8. I agree not to share, sell or trade my medication(s).
9. I agree not to obtain any controlled medicines, including opioid pain medicine, controlled stimulants or anti-anxiety medicines from any other doctor, without my doctor's knowledge.
10. I agree that the pharmacy and my doctor may communicate freely. All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacy; I will inform the clinic within 2 business days. The pharmacy that I have selected is _____, phone # _____. Individuals I authorize to pick up my prescription(s) if I am unable to are (limit of two): (1) _____ (2) _____. **A photo ID is required.**
11. **(A)** I understand that in the event of an allergic reaction, I must contact my physician's office as soon as possible or if this occurs at night or on the weekend, contact the on-call physician or go to the Emergency Department. **(B)** I further understand that in the event of an allergic reaction, side effects, or inadequate response, I will be required to bring all medications to the office before any new prescriptions can be considered. **(C)** I will also bring the rejected medication to my next visit.
12. I understand that the following are some examples of conditions for termination from the clinic: **(A)** Obtaining pain medication from any other physician while receiving them here without notifying us within 2 business days; **(B)** Altering or forging a prescription which is a felony and will be reported; **(C)** Non-compliance with any drug screen or pill count requested by the clinic; **(D)** Failure to keep clinic appointments or notify clinic more than 24 hours in advance of appointment; and **(E)** Misuse of medications.
13. I understand that the manufacturer of prescription narcotics/controlled substances, muscle relaxants, tranquilizers, etc. recommend that a person not operate heavy machinery (this includes a motor vehicle); and that my doctor cannot recommend that I act against the manufacturers' recommendation and will assume **NO** liability should I do so.
14. I authorize any physician providing treatment to me, as well as pharmacists, to cooperate fully with any city, state or federal law enforcement agency, including TN Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize the clinic to provide a copy of this agreement to my pharmacy or any other physician who has treated me. I agree to waive any applicable State or Federal privilege or right of privacy or confidentiality with respect to these authorizations.

I have read, understood and agree to the above conditions for receiving pain and controlled substances.

_____	_____	_____	_____
Patient signature	Date	Office Staff or MD	Date

Tri-State Mountain Neurology Associates

Financial Payment Policy

Thank you for choosing Tri-State Mountain Neurology as your healthcare provider. We are committed to your neurological well-being and health. In an effort to ensure that patients are familiar with our payment policy, we are asking that after you read this, you sign on the line below in acknowledgement. Please let us know if you have any questions or concerns.

You will want to be sure that Tri-State Mountain Neurology Associates is a participating provider in your insurance plan before receiving care from us to avoid being personally responsible for the payment at the time of service.

If your insurance situation changes, let us know as soon as possible to also avoid unexpected charges. We happily will bill your insurance provider for you once, but your insurance policy is between you and your insurance provider.

To keep cost down, co-pays and deductibles are due prior to treatment; if billing is necessary, there will be a $9 billing fee.

We gladly accept cash, check or VISA/MASTERCARD. There is a $35 service fee for returned checks.

After allowing your insurance company sixty (60) days to remit, payments not paid in full are your responsibility and will be billed to you.

Missed appointments are costly to the physicians and the patients in their care. Please help us to serve you better by keeping scheduled appointments or by cancelling an appointment 24 hours in advance also avoiding a possible $50 appointment charge.

All of us at Tri-State Mountain Neurology Associates are committed to serving you in the most effect manner possible, and we appreciate your assistance in these matters. Thank you.

By signing below I acknowledge I have read, understand and agree to abide by these payment policies of Tri-State Mountain Neurology Associates,

_____ _____

Signature Date