Mission Statement

Prosthetic & Orthotic Solutions, LLC. is dedicated to improving patient outcomes. By working closely with other healthcare professionals, Prosthetic & Orthotic Solutions, LLC. delivers the highest quality of care and products that patients deserve.

Please review the attached packet of information carefully as it includes our warranty and payment policies, privacy practices, and patient bill of rights.

NOTICE OF PRIVACY PRACTICES FOR PROSTHETIC & ORTHOTIC SOLUTIONS, LLC.

If you have any questions about this Notice please contact: our Privacy Contact, Craig Babyak, Owner of Prosthetic & Orthotic Solutions, LLC. at (413) 785-4047.

OUR COMMITMENT TO PROTECT YOUR HEALTH INFORMATION

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Your "protected health information" means any of your written and oral health information, including your demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

We are strongly committed to protecting your medical information. We create a medical record about your care because we need the record to provide you with appropriate treatment and to comply with various legal requirements. We transmit some medical information about your care in order to obtain payment for the services you receive, and we use certain information in our day to day operations. This Notice will let you know about the various ways we use and disclose your medical information, describe your rights and our obligations with respect to the use or disclosure of your medical information. We will also ask that you acknowledge receipt of this Notice the first time you come to or use any of our facilities, because the law requires us to make a good faith effort to obtain your acknowledgment.

We are required by law to:

- Make sure that any medical or health information that we have that identifies you is kept private, and will be used or disclosed only in accord with this Notice of Privacy Practices and applicable law;
- Give you this Notice of our legal duties and our privacy practices; and
- Abide by the terms of the Notice of Privacy Practices that is in effect from time to time.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Uses and Disclosures of Protected Health Information for Treatment, Payment and Healthcare Operations

Your protected health information may be used and disclosed by your **(Orthotist or Prosthetist)**, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of this facility.

Following are examples of the types of uses and disclosures of your protected health care information that this facility is permitted to make. We have provided some examples of the types of each use or disclosure we may make, but not every use or disclosure in any of the following categories will be listed.

For Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related treatment. 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 the physician that referred you to us. We will also disclose protected health information to other health care providers who may be treating you.

For Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review

activities. We may also tell your health plan about an orthotic or prosthetic device you are going to receive to obtain prior approval or to determine whether your plan will cover the device.

For Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this facility. These activities include, but are not limited to: quality assessment activities, employee review activities, legal services, licensing, and conducting or arranging for other business activities. We may share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for this facility. Whenever an arrangement between our facility and our business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Treatment Alternatives: We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Appointment Reminders: We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Sign In Sheets: We will not use a sign-in sheet at the registration desk in order to protect your privacy. We may call you by name in the waiting room when your **(Orthotist or Prosthetist)** is ready to see you or if we need you to come to the check in/out window to gather more information.

Marketing and Health-Related Benefits and Services: We may also use and disclose your protected health information for other marketing activities. For example, we may send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Sale of the Practice: If we decide to sell this practice or merge or combine with another practice, we may share your protected health information with the new owners.

B. Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization, at any time, in writing. You understand that we cannot take back any use or disclosure we may have made under the authorization before we received your written revocation, and that we are required to maintain a record of the medical care that has been provided to you. The authorization is a separate document, and you will have the opportunity to review any authorization before you sign it. We will not condition your treatment in any way on whether or not you sign any authorization.

C. Other Permitted and Required Uses and Disclosures That May Be Made Either With Your Agreement or the Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your **(Orthotist or Prosthetist)** may, using their professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, orally or in writing, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional

judgment. We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition.

D. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to object.

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by federal, state or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. A disclosure under this exception would only be made to somebody in a position to help prevent the threat to public health.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. We will only make this disclosure if you agree or when required or authorized by law. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Military and Veterans: If you are a member of the military, we may release protected health information about you as required by military command authorities.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems and biologic product deviations, or to track products to enable product recalls, or to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes might include: (1) legal processes and otherwise required by law; (2) limited information requests for identification and location purposes; (3) pertaining to victims of a crime; (4) suspicion that death has occurred as a result of criminal conduct; (5) in the

event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the **FACILITY**'s premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaver organ, eye or tissue donation purposes.

Research: Under certain circumstances, we may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs that provide benefits for work-related illnesses and injuries.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your **(Orthotist or Prosthetist)** created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures 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 the final rule on Standards for Privacy of Individually Identifiable Health Information.

2. YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your protected health information contained in your medical and billing records and any other records that your **(Orthotist or Prosthetist)** uses for making decisions about you, for as long as we maintain the protected health information.

To inspect and copy your medical information, you must submit a written request to the Privacy Contact listed on the first and last pages of this Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

We may deny your request in limited situations specified in the law. For example, you may not inspect or copy psychotherapy notes; or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and certain other specified protected health information defined by law. In some circumstances, you may have a right to have this decision reviewed. The person conducting the review will not be the person who initially denied your request. We will comply with the decision in any review. Please contact our Privacy Contact if you have questions about access to your medical record.

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 (Orthotist or Prosthetist) is not required to agree to a restriction that you may request. If the **(Orthotist or Prosthetist)** 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. If your **(Orthotist or Prosthetist)** does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your **(Orthotist or Prosthetist)**. You may request a restriction by contacting the privacy contact mentioned on page two in writing.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your (Orthotist or Prosthetist) amend your protected health information. This means you may request an amendment of your protected health information contained in your medical and billing records and any other records that your **(Orthotist or Prosthetist)** uses for making decisions about you, for as long as we maintain the protected health information. You must make your request for amendment in writing to our Privacy Contact, and provide the reason or reasons that support your request.

We may deny any request that is not in writing or does not state a reason supporting the request. We may deny your request for an amendment of any information that:

1. Was not created by us, unless the person that created the information is no longer available to amend the information;
2. Is not part of the protected health information kept by or for us;
3. Is not part of the information you would be permitted to inspect or copy; or
4. Is accurate and complete.

If we deny your request for amendment, we will do so in writing and explain the basis for the denial. You have the right to file a written statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right only applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It also excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes.

You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. You must submit a written request for disclosures in writing to the Privacy Contact. You must specify a time period, which may not be longer than six years and cannot include any date before April 14, 2003. You may request a shorter timeframe. Your request should indicate the form in which you want the list (i.e., on paper, etc). You have the right to one free request within any 12 month period, but we may charge you for any additional requests in the same 12 month period. We will notify you about the charges you will be required to pay, and you are free to withdraw or modify your request in writing before any charges are incurred.

You have the right to obtain a paper copy of this notice from us, upon request to our Privacy Contact, or in person at our office, at any time.

3. COMPLAINTS You may complain to 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 contact of your complaint. We will not retaliate against you in any way for filing a complaint, either with us or with the Secretary.

You may contact our Privacy Contact, **Craig Babyak at (413) 785-4047** or **email him at craigb@pandosolutions.com** for further information about the complaint process.

4. CHANGES TO THIS NOTICE We reserve the right to change the privacy practices that are described in this Notice of Privacy Practices. We also reserve the right to apply these changes retroactively to Protected Health Information received before the change in privacy practices. You may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of your next appointment, or accessing our website.

This notice became effective on April 15, 2003 and was revised on April 10, 2013.

WARRANTY POLICY

The warranty period for custom orthoses and prostheses is three months for workmanship and materials. Although **Prosthetic & Orthotic Solutions, LLC.** cannot be responsible for physiological or anatomical changes in a patient's medical condition, we will attempt to maintain proper fit during this period. Normal adjustments to enhance fit will be made at the discretion of the practitioner at no charge for a period of up to one year. Additions of components, straps, lifts, etc. prescribed by a physician will incur a charge. There will be a separate charge for adjustments or repairs that are made as a result of abuse or tough wear, as may occur from sporting, vocational, or unusual activities.

Since orthoses and prostheses are prescribed at the direction of a physician, and are custom fabricated for the anatomy and medical condition of each individual, they cannot be returned for credit or refund. Prescribed "off the shelf" items cannot be returned for hygienic reasons. Certain products may have an additional warranty if they are manufactured by a company other than Prosthetic & Orthotic Solutions, LLC.

Please communicate any problems or discomfort you are experiencing to your practitioner immediately to allow us to resolve these problems as efficiently and quickly as possible. We will make every attempt to meet your needs. Please contact the Clinical Manager if there is a question or concern that your practitioner cannot resolve for you. Thank you.

PAYMENT AGREEMENT

To prevent any misunderstanding about medical insurance, we wish to point out that: **(1) Payment for all medical services furnished are the responsibility of the patient**; (2) Deductibles and/or co-payments are due at the time services are rendered; (3) Fifty percent (50 %) of the balance for non-covered custom-made devices is due at the time of cast and measure, with the balance due at the time of delivery; (4) **Prosthetic & Orthotic Solutions, LLC.** will bill your insurance company as a courtesy to you, however, **Prosthetic & Orthotic Solutions, LLC.** is not responsible for non-payment from the insurance company; (5) If, due to unforeseen circumstances, additional procedures and/or treatments are necessary beyond what has been previously approved, patients must make

arrangements for payment; (6) Patients are expected to keep their accounts current while waiting for their insurance company to remit payment.

Your insurance coverage is a contract between you and your insurance company to help you meet medical expenses. Because benefits can vary greatly, it is not possible for **Prosthetic & Orthotic Solutions, LLC.** to provide services on the basis that your insurance company will pay all charges.

Prosthetic & Orthotic Solutions, LLC. can in no way guarantee coverage. Benefits are determined by your insurance at the time your claim is processed. All benefit calculations are only an estimate, based on information obtained from your insurance company. The actual final Total Patient's Responsibility may be different than what was previously calculated by **Prosthetic & Orthotic Solutions, LLC.**

Payments may be made by cash, check, money order, Visa, MasterCard, American Express or Discover.
A $20.00 fee will be assessed for any check returned for any reason.

FINANCIAL POLICY

Thank you for choosing Prosthetic & Orthotic Solutions, LLC. Where we are committed to the success of your care. Please understand that payment of your bill is part of this treatment and care. Our staff is available to answer any specific billing questions you may have. The following information is provided as a courtesy to clarify your financial responsibility related to professional services provided by Prosthetic & Orthotic Solutions, LLC. This document does not cover all situations and should not be construed to be an all-inclusive listing of all possible situations. As part of our commitment of service to you, we will make every attempt to verify your insurance benefits at the time your services are rendered. However, insurance verification or authorization is not a guarantee of insurance payment. This only allows our office to provide you with a preliminary estimate of any monies due by the insured at the time of delivery of the device. Your patient portion is subject to change based on final claim determination by your insurance carrier.

What Is My Financial Responsibility for Services? Your financial responsibility depends on a variety of factors, explained below.

FEE EXPLANATION The fees that we charge include all materials used and all time necessary for measuring, fabricating, and the initial fitting for a particular item or procedure. Needed adjustments or repairs that are done within the warranty period of the initial fitting or are a part of the initial fitting will be done at no additional charge. There will be a separate charge for adjustments or repairs that are made after a lapsed time of the initial fitting.

INSURANCE BILLING Please advise us immediately if you are insured. As a courtesy, Prosthetic & Orthotic Solutions, LLC. will bill your insurance carrier(s) for you after verification of covered services. If an item is considered non-covered by your insurance carrier we may ask that the entire balance be paid in full upon delivery. We may also ask that you pay any coinsurances and/or deductibles at the time of delivery.

MEDICARE BILLING We will bill your Medicare carrier for covered services. At the time services are provided, we require a payment for your portion of the charges plus any deductible that remains. If you have a secondary carrier we may bill them for your coinsurance and/or deductible provided the item is considered covered.

MEDICAID BILLING Medicaid claims may require a prior authorization before any services can be provided and some Commonwealth care Plans may have coinsurances.

AUTO INSURANCE Prosthetic & Orthotic Solutions, LLC. may bill your auto insurance as long as the patient provides all appropriate claim information prior to delivery. If your medical equipment is related to an injury sustained in an auto accident we will also require ALL health insurance information be confirmed in case the PIP is exhausted at the time of billing. If you choose not to provide us with your health insurance information we may ask that you pay the entire balance at the time of delivery.

WORKERS' COMPENSATION Prosthetic & Orthotic Solutions, LLC. may bill your workers' compensation claim on your behalf as long as prior approval is received prior to delivery. If your medical equipment is related to

an injury sustained in your place of employment we will also require ALL health insurance information be confirmed.

BILLING PROCEDURE We mail monthly statements at the end of each month. Payment is due upon receipt.

SPECIAL NEEDS We understand that it may be necessary to set up a payment plan. If this is needed for you, please let us know as soon as possible. With prior arrangements we can set up a reasonable payment plan.

URGENT CARE

Prosthetic & Orthotic Solutions, LLC. is aware of the importance of our patient's wearing of the orthosis or prosthesis that has been provided. In the event that an orthosis or prosthesis is in the need of immediate repair, it will receive the highest priority and every effort will be made to repair or replace the device as soon as possible. In the event that an urgent need arises concerning your orthosis or prosthesis, please call the office that provided you the device. A **Prosthetic & Orthotic Solutions, LLC.** representative will return your call as soon as possible, during normal business hours.

PATIENT COMPLAINT PROCESS

We are committed to ensuring you are completely satisfied with the services and care you receive at **Prosthetic & Orthotic Solutions, LLC.** However, if for any reason you wish to file a complaint, any staff member can assist you in this confidential matter. You will be asked to complete a "Patient Complaint Form" to assist us in understanding your complaint or concern fully. Once the form is received, a company representative will investigate the complaint thoroughly and take the necessary actions to satisfy your complaint. *(You will be notified of the receipt and actions taken, as appropriate, within 3 business days of receipt of your Patient Complaint Form.)*

PATIENT BILL OF RIGHTS

Every Patient has the right to:

- **Be treated with dignity and respect.**
- **Receive complete and current information regarding his/her diagnosis, treatment and prognosis in terms he/she can understand. When it is not medically advisable to give the information to the patient, it will be made to the appropriate person on his/her behalf.**
- **Know by name and specialty, the practitioner responsible for the coordination of care.**
- **Receive services regardless of age, race, religion, sex, social status, political belief, disability or diagnosis.**
- **Privacy and confidentiality regarding information and records about his/her care and may approve or refuse to release information to any individual outside Prosthetic & Orthotic Solutions, LLC. except as provided by law or a third party payment contract and in accordance with HIPAA privacy standards.**
- **Expect Prosthetic & Orthotic Solutions, LLC. to make a reasonable response to his/her requests.**
- **Obtain information on the relationship of Prosthetic & Orthotic Solutions, LLC. to other health care and related institutions insofar as his/her care is concerned.**
- **Receive reasonable coordination and continuity of care.**
- **Know the cost of care and treatment and receive and explanation of his/her financial responsibility upon request.**
- **Participate in decisions concerning his/her care and to refuse to participate in experimental treatment.**
- **Express dissatisfaction and suggest changes in any service without coercion, discrimination, reprisal, or unreasonable interruption of service.**
- **Receive information on Prosthetic & Orthotic Solutions, LLC.'s policies for receiving, reviewing, and resolving customer complaints.**
- **Be fully informed of Prosthetic & Orthotic Solutions, LLC.'s policies, procedures, and charges for services including criteria for third party reimbursement and receive and explanation of all forms that are requested to be signed.**