

**Marine City Medical Clinic  
130 Washington Street  
Marine City, MI 48039**

## **HIPAA Notice of Privacy Practices**

This notice describes how medical information about you may be used and disclosed by **Marine City Medical Clinic** and how you can get access to this information. **Please review it carefully.**

### **Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

#### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

#### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

#### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

#### **Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

#### **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

#### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

#### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us directly at: **Marine City Medical Clinic; 130 Washington Street; Marine City, MI 48039 or call 810-765-8750**
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling , calling 1-877-696-6775.

- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

## Our Uses and Disclosures

### How do we typically use or share your health information?

We typically use or share your health information in the following ways.

#### Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

#### Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

#### Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

### How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

#### Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

### **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

### **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### **Address workers' compensation, law enforcement, and other government requests**

- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

## **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice is effective as of the date that this document is signed.

In signing this document, I acknowledge that I have received and agree to terms outlined in the HIPAA Notice of Privacy Practices.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Financial Agreement

**Marine City Medical Clinic  
130 Washington Street  
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Thank you for choosing our services for your needs. Please read and sign the agreement below. It lays out billing, scheduling and cancellation procedures. If you have any questions please ask for clarification.

- Payment of all fees is expected at the time of service or via credit card on file.
- It is the client's responsibility to pay at time of service, unless other arrangements have been made and agreed upon prior to appointment.
- I hereby authorize payment of medical benefits directly to Marine City Medical Clinic for all services rendered where applicable.
- Out-of-pocket payments can be made via credit/debit card, cash or check and are due on the date of your appointment. Please make checks payable to Marine City Medical Clinic. There is a \$35 fee for all returned checks.
- I will be responsible to pay a \$50 late cancel fee for any missed or canceled initial visits, not made at least 24 hours in advance prior to the scheduled appointment time.
- If I default on my account, I understand I will be subject to finance and/or legal fees in addition to the total account balance.

I agree to the above financial and cancellation policies. In the case of default payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account. I understand the scope and limitations of my insurance coverage and agree to pay all fees not covered by my insurance plan. I have read, understand, and accept the information and conditions specified in this agreement.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Emergency Contacts: The person(s) below are my emergency contacts.

1.

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| Name | Phone number | Relationship |
|------|--------------|--------------|
|------|--------------|--------------|

2.

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| Name | Phone number | Relationship |
|------|--------------|--------------|
|------|--------------|--------------|

**Patient authorization to release private health information**

The person(s) listed below may have information contained in my medical record. This release includes protected health information.

Please list the names of persons you are allowing to have protected health information about you. If the answer is none, then write none and sign and date.

1.

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| Name | Relationship |
|------|--------------|
|------|--------------|

2.

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| Name | Relationship |
|------|--------------|
|------|--------------|

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Patient signature

Date