The Orthotic & Prosthetic Centers

Patient Information

Name _____ Male / Female Date of Birth _____

Home Address _____

City _____ State _____ Zip _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Best Phone to Reach You _____ Best Time to Reach You Between 9 and 5 _____

SS# _____ Marital Status _____ Email _____

Diagnosis _____ Do you have Diabetes? YES / NO

Physician Information

Referring Physician _____ Phone _____

Primary Physician _____ Phone _____

☐ **Responsible Party** (if different from patient) ☐ **Emergency Contact** ☐ **Other**

Responsible Party Name _____ Date of Birth _____

Relationship to Patient _____ Email _____ Phone _____

Mailing Address _____

City _____ State _____ Zip _____

Insurance Information

Primary Insurance _____

Subscriber _____ Subscriber Employer _____

ID# _____ Group# _____

Secondary Insurance _____

Subscriber _____ Subscriber Employer _____

ID# _____ Group# _____

Other Insurance _____

ID# _____ Group# _____

Worker's Compensation / Accident Information

Is this a Worker's Compensation claim? Yes / No Date of Injury _____

Is this due to an auto/home accident? Yes / No Date of Accident _____

Employer Claims Contact _____ Phone _____

I attest the above information is correct. I authorize The Orthotic and Prosthetic Centers to release necessary information to my insurance carriers to process my medical claim. I also authorize my insurance carrier to pay benefits directly to The Orthotic and Prosthetic Centers. As the responsible party, I understand I am responsible for the entire amount of my claim and that insurance benefits may be limited or non-existent.

Signature _____ Relationship to Patient _____ Date _____

Patient Acknowledgement Form

The Orthotic & Prosthetic Centers

You will be receiving information on several policies and procedures we have implemented to ensure that your treatment is of the highest quality while in our care. This acknowledgement indicates your receipt of such information at the time of your initial visit.

Patient Bill of Rights

This details your rights as a patient (copy located in brochure).

HIPPA Privacy Notice

By signing below, you consent to the use and disclosure of your protected health information by The Orthotic and Prosthetic Centers, our staff, and our business associates for treatment, payment, and health care operations purposes. For a more detailed description of our uses and disclosures of protected health information, please review our Notice of Information Practices ("Notice"), which you acknowledge receiving on this date. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised copy by contacting us at the above address or phone number and requesting a revised Notice. You have the right to request in writing, that we restrict our disclosures of your protected health information that we would otherwise be permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it (copy located in brochure).

Medicare Supplier Standards

Outlines standards that are to be maintained by The Orthotic and Prosthetic Centers as a Medicare provider (copy located in brochure).

Assignment of Benefits

I hereby authorize The Orthotic and Prosthetic Centers to release necessary medical information to my insurance carrier(s) to process my medical claim. I also authorize my insurance carrier to pay benefits directly to The Orthotic and Prosthetic Centers. I understand that I am responsible for the entire amount of my claim and that insurance benefits may be limited or non-existent.

Consent to Treat

I hereby authorize The Orthotic and Prosthetic Centers to provide requested orthotic and/or prosthetic services.

Consent to Treat Minor

I, _____ hereby authorize and request the designated clinicians and/or designated assistants of The Orthotic and Prosthetic Centers to provide the needed orthotic and/or prosthetic services for

_____ (minor's name).

YES / NO Have you received a like or similar device within the last 5 years from either The Orthotic and Prosthetic Centers or any other provider?

YES / NO Are you currently residing in a nursing home?
Name of Home _____

YES / NO Do you have surgery scheduled to treat the same condition for which this device will be utilized?

I, the undersigned, have received the above documents, read and understand these policies and agreements and hereby consent to the above. I also attest that the above questions have been answered truthfully to the best of my knowledge.

_____ _____

Signature of Patient or Responsible Party | Date

_____ _____

Print Name of Patient or Responsible Party | Relationship

The Orthotic & Prosthetic Centers

Providing Superior Orthotic, Prosthetic and Pedorthic Services in Pediatric and Adult Care

Welcome to The Orthotic & Prosthetic Centers

The Orthotic and Prosthetic Centers provides superior orthotic, prosthetic, and pedorthic services in pediatric and adult care utilizing the most advanced materials, technology and leading research in the field.

Our dedicated staff of prominent orthotic and prosthetic clinicians and highly skilled technicians shares a commitment to meeting the needs of our patients and surpassing their expectations for care. Collaboration with physicians, therapists and other healthcare professionals, and a partnership with the leading manufacturer of orthotic and prosthetic devices ensures a full spectrum of services from a team of experts in each field.

The Orthotic and Prosthetic Centers are located conveniently throughout Eastern Massachusetts, from Boston North, Greater Boston Metropolitan Area, and the South Shore to Cape Cod and the Islands and Northwest Rhode Island.

How to Contact Our Office

For medical emergencies, please contact your physician or call 911.

We can be reached for all offices during normal working hours at 800 634 0606.

We have an answering system so that you may leave a message for us when we are not in the office. Please speak clearly and be sure to leave your name and phone number. We will return your call as soon as possible.

Our office hours are Monday through Friday 8:30 am to 5:00 pm

Billing Policies

We are participating providers with many insurance companies and will accept their approved fee amounts. Patients will be responsible for all copays, co-insurance, deductibles and subscriber liability amounts. We will submit claims to other insurance companies but the patient will be responsible for payment in full for services rendered.

We ask all patients to pay 50% (fifty percent) of their balance when the device is ordered. The remaining amount is due when the device is delivered to the patient. We will make this information available to you as early as possible in the assessment for a device process.

Adjustments in fitting the device may be provided free of charge.

We accept cash, checks, money orders and credit cards (Visa, Master Card and American Express)

Payment plans are available upon request prior to the device being delivered.

Fee Schedule

Our fee schedule is available upon request

Warranty

Devices are fully guaranteed under normal use for 90 days. The Orthotic and Prosthetic Centers will make any repairs to devices, as necessary and free of charge, during the warranty period. This guarantee does not apply to changes in the patient's physical weight, condition, nor any other physiological changes that may occur, or to any alterations made by anyone other than the staff at the Orthotic and Prosthetic Centers.

Problems, Complaints, Compliments

We always want to hear from you. If you have a problem or complaint, please call or write the office manager. They will be happy to assist you. We have a complaint resolution process and will try our best to resolve any problems to your satisfaction.

Compliments are always nice to hear. Please call or write to us if you think we are doing a good job. It is a pleasure to know that we were able to assist you.

PATIENT BILL OF RIGHTS

1. Every patient shall have the right to considerate and respectful care.

2. Every patient can reasonably expect complete and current information concerning 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 may be made available to the appropriate person on his/her behalf.

3. Every patient shall have the right to know by name and specialty, if any, the practitioner responsible for coordination of his/her care.

4. Every patient shall have the right to every consideration of his/her privacy and individuality as it relates to his/her social, religious and psychological well-being.

5. Every patient shall have the right to respectfulness and privacy as it relates to his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly.

6. Every patient shall have the right to expect The Orthotic and Prosthetic Centers to make reasonable response to his/her requests.

7. Every patient shall have the right to obtain information on the relationship of The Orthotic and Prosthetic Centers to other health care and related institutions insofar as his/her care is concerned.

8. Every patient shall have the right to expect reasonable continuity of care. This shall include but not be limited to what appointment times and practitioners are available.

9. Every patient shall be fully informed prior to treatment of the services available in The Orthotic and Prosthetic Centers and of related charges, including any charges for services not covered under Medicare or Medicaid.

10. Every patient shall have the opportunity to participate in the planning of his/her medical treatment and to refuse to participate in experimental research.

11. Every patient shall be assured confidential treatment of his/her personal records, and may approve or refuse their release to any individual outside The Orthotic and Prosthetic Centers except as otherwise provided by law or as stated in The Orthotic and Prosthetic Centers Notice of Privacy Practices.

12. Every patient shall be fully informed, prior to treatment, of the rights and responsibilities set forth in this section and of all rules governing patient conduct and responsibilities.

CMS Medicare Orthotic and Prosthetic Supplier Standards

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.

2. A supplier must provide complete and accurate information on the DME-POS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.

3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.

4. A supplier must fill orders from its own inventory or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs or from any other Federal procurement or non-procurement programs.

5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment and of the purchase option for capped rental equipment.

6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law and repair or replace free of charge Medicare covered items that are under warranty.

7. A supplier must maintain a physical facility on an appropriate site

8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours and must maintain a visible sign and posted hours of operation.

9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine or cell phone is prohibited.

10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.

11. A supplier must agree not to initiate telephone contact with beneficiaries with a few exceptions allowed. This standard prohibits suppliers from calling beneficiaries in order to solicit new business.

12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items and maintain proof of delivery.

13. A supplier must answer questions and respond to complaints of beneficiaries and maintain documentation of such contacts.

14. A supplier must maintain and replace at no charge or repair directly or through a service contract with another company Medicare-covered items it has rented to beneficiaries.

15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.

16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.

17. A supplier must disclose to the government any person having ownership, financial or control interest in the supplier.

18. A supplier must not convey or reassign a supplier number (e.g., the supplier may not sell or allow another entity to use its Medicare billing number).

19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.

20. Complaint records must include the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.

21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.

22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals). Implementation date – October 1, 2009.

23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.

24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.

25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.

26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c). Implementation date- May 4, 2009.

27. A supplier must obtain oxygen from a state – licensed oxygen supplier.

28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).

29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.

30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

HIPAA

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. For questions please contact us at: 800 634 0606 or at The Orthotic & Prosthetic Centers, 164 Mid Tech Drive Suite E, West Yarmouth, MA 02673.

OUR COMMITMENT TO PROTECT YOUR HEALTH INFORMATION

This Notice of Privacy Practices outlines our practices, policies, and legal duties to maintain and protect against prohibited disclosure of your protected health information under the privacy regulations mandated by the Health Insurance Portability and Accountability Act ("HIPAA Privacy") and further expanded by the Health Information Technology for Economic and Clinical Health Act ("HITECH") provisions in Title XIII of the American Recovery and Reinvestment Act ("ARRA"). This Notice 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: 1.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; 2. Give you this Notice of our legal duties and our privacy practices; and 3. 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 clinician, 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 your protected health information in order to support the business activities of this facility that are included within the definition of "health care operations" within the HIPAA Privacy regulations & as revised by HITECH. These activities include, but are not limited to: quality assessment activities, employee review activities, legal services, licensing, & conducting or arranging for other business activities. We may share your protected health information with third party "business associates" that perform various activities 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 may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room.

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 owner.

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 can not 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 clinician 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 & 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 Orthotic Center'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 & 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 clinician 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

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 clinician 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 from being disclosed to a health plan for purposes of carrying out payment of health care operations if the protected health information pertains to an item or service for which we have been paid out-of-pocket in full.

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 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 clinician is not required to agree to a restriction that you may request. If the clinician 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 clinician 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 clinician. You may request a restriction by submitting a request 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 clinician 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 clinician 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 disclosure we have made of your electronic health record for treatment, payment or healthcare operations.

Beginning January 1, 2001, we will provide an accounting of disclosures of electronic health records for treatment, payment and health care operations during the three-year period preceding your request or from the date we began maintaining protected health information in an electronic format, whichever is greater.

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 access to your electronic health record upon request. You may obtain access to your protected health information contained in an electronic health record, and to direct us to send a copy of your electronic health record to a third party.

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, even if you have agreed to accept this notice electronically.

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. 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 Contacts by phone or by mail at the address at the beginning of this document 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 **February 17, 2010.**

The Orthotic & Prosthetic Centers

800 634 0606

Boston

Braintree

Concord

Methuen

Newton

North Smithfield

Plymouth

West Yarmouth

oandpcenters.com
info@oandpcenters.com