NORTHERN PINES
HEALTH CENTER, PC

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

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

Dear New Patient:

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

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

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

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

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

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

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

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

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

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

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

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Personal Health Information Release

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

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

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

Name_____ Relation_____ Phone #_____

Name_____ Relation_____ Phone #_____

Name_____ Relation_____ Phone #_____

Name_____ Relation_____ Phone #_____

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

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

Initial_____ Phone Number_____

Initial_____ Phone Number_____

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

Patient or Legal Representative Signature _____Date: _____

Patient Name: _____ Date of Birth:_____

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HEALTH CENTER, PC

Authorization for Release of Health Information

Please complete all sections below.

SECTION 1: Patient Information (Please Print)

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

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

In order to disclose protected health information for any reason other than treatment, payment, health care operations, performing certain insurance functions, or as otherwise required or authorized by law, Northern Pines Health Center and its health professionals and staff (collectively the "Practice") must obtain your signed authorization. Complete the following to indicate those items you authorize the Practice to disclose. To authorize the disclosure of all health information which the Practice creates, receives or maintains, check the first box.

I authorize the Practice to disclose the health information checked below concerning my care/the above-named patient. I understand that this information may include, when applicable, information relating to Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex), behavioral or mental health services (excluding psychotherapy notes), and/or information that might identify the above-named patient (directly or indirectly) as having or having had a substance use disorder (as permitted by MCL §330.1748, MCL §330.1262, and/or 42 CFR Part 2).

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

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

_____ **EXCLUSIONS:** If initialed here, I DO NOT authorize the Practice to disclose the following health information concerning the above-named patient.

_____

_____

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

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

_____

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

○ Northern Pines Health Center – 11293 N M-37 Suite A, Buckley, MI 49620 Phone:231-269-4185 Fax: 231-269-4461

⬭ **Mitzie Hewitt, DO** ⬭ **Christina Peltier, FNP-C** ⬭ **Tessa Sprague, PA-C** ⬭ **Abby St Louis, FNP-C**

○ Myself – Paper copy via US Mail to address in Section 1
○ Other: I am the patient, or the legally authorized representative of the patient listed in Section 1 and request the protected Health Information as indicated on this form to be released to:

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

SECTION 5: Select Delivery Method for Protected Health Information

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

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

SECTION 6: Purpose of Request/Disclosure:

- Personal Use
- Continuation of Care
- Other (Please Specify):_____

SECTION 7: Signature of Patient or Patient Representative

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

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

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

_____ _____ _____

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

_____

Legal Representative Relationship to Patient

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

_____ _____ _____

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

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

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

DATE: ___/____/____ EVENT: _____ CONDITION: _____

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

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

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Patient Portal Authorization Form

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

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

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

How the Secure Patient Portal Works:

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

Instructions for Accessing the Patient Portal:

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

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

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

Protecting Your Private Health Information and Risks:

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

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

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

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

Patient Acknowledgement and Agreement:

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

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

Secure Email Address:_____

Print Name:_____ Date of Birth: _____

Patient Signature:_____Date:_____

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

NORTHERN PINES
HEALTH CENTER, PC

Patient Portal Proxy Access Form

1. Patient Information

Patient Name: _____ Patient Date of Birth: _____

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

Proxy Name: _____Proxy Date of Birth: _____

Proxy Email Address: _____

Adult Patient	**Minor Patient**
Access to another adult's Patient Portal record. **Select One:** ☐ **Adult Patient** • The patient should sign this form to provide authorization for release of their medical information. • Authorization for proxy access is valid until revoked by patient. ☐ **Legal Representative of Adult Patient:** (Adults who have a surrogate relationship with another adult through a legal arrangement) **Select the option below that best describes the relationship:** ☐ Legal Guardian (court order) ☐ DPOA for Health Care • If you are a legal guardian or you have a durable power of attorney for healthcare for this patient, then this request **must** be verified by the legal paper work confirming your authority to have access to the patient's medical information. • You must notify the hospital immediately in case of any change in authority.	**Access to your minor child's Patient Portal record.** (Note: Individuals requesting access must have parental rights or legal guardianship rights.) **My relationship to the child is:** ☐ Parent ☐ Permanent Legal Guardian of the Patient-must verify the Court Order Appointing Guardian and letters of Guardianship confirming the Proxy's status as permanent legal guardian of the patient. **Select One:** ☐ **Patient Age 0-12:** You will be granted access to your child's portal until the child turns 13 years old. ☐ **Patient Age 13-17:** You will be granted access to your teenage child's portal if your child signs an authorization form. • Authorization for proxy access is valid until revoked by parent/permanent legal guardian or child.

Authorization:

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

By signing below, parents acknowledge and agree that:

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

Legal Representatives:

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

By signing below, I acknowledge and agree that:

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

X_____ _____

Patient Signature* **Date**

X_____ _____

Parent or Legal Representative Signature* **Date**

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

NORTHERN PINES
HEALTH CENTER, PC

NORTHERN PINES HEALTH CENTER CONSENT FORMS

FINANCIAL POLICY

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

Usual and Customary

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

Payment at Time of Service

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

Insurance

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

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

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

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

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

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

Patients with NO Medical Insurance

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

Minor Patients

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

Returned Checks

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

Scheduled Medications

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

Delinquent Accounts

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

Care Management

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

CONSENT FOR TREATMENT/FINANCIAL AUTHORIZATION

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

****NOTICE****

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

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

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

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

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

NORTHERN PINES
HEALTH CENTER, PC

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

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

Privacy Officer: Keisha Sexton

Notice of Privacy Practices

Effective Date: February 16, 2026

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.

Your medical information is personal. We are committed to protecting your medical information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office whether made by your personal physician or one of the office's employees.

This Notice will tell you about the ways in which we may use and disclose your medical information. This Notice will also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

This office is required by law to:

1. make sure that medical information that identifies you is kept private;
2. give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
3. follow the terms of the Notice that is currently in effect.

If you have questions about this Notice, please contact our Privacy Officer at (231) 269-4185.

HOW THIS OFFICE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION:

The following describes the different ways that your medical information may be used or disclosed by this office. For clarification we have included some examples. Not every possible use or disclosure is specifically mentioned. However, all of the ways we are permitted to use and disclose your medical information will fit within one of these general categories:

For Treatment. We will use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians and other office personnel who are involved in providing you medical treatment.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received here so your health plan will pay us or

reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, and other office personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identity of the specific patients.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at this office.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve accessing a patient registry which includes all patients of a specific diagnosis.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, disclosure may be required by Workers' Compensation statutes and various public health statutes in connection with required reporting of certain diseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Health Oversight Activities. We may disclose medical information to a governmental or other oversight agency for activities authorized by law. For example, disclosures of your medical information may be made in connection with audits, investigations, inspections, and licensure renewals, etc.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may use your medical information to defend the office or to respond to a court order.

Law Enforcement. We may release medical information about you if required by law when asked to do so by a law enforcement official.

Coroners and Medical Examiners. We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death.

Uses and Disclosures Requiring an Authorization

Other uses and disclosures of your medical information not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us such an authorization in writing to use or disclose medical information about you, you may revoke that authorization, in writing, at any time, except to the extent that we have acted in reliance of

it. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. The following are examples of uses and disclosures requiring an authorization:

Psychotherapy Notes. If we maintain information which qualifies as "psychotherapy notes" as defined below, we must obtain an authorization for any use or disclosure of psychotherapy notes, except: (i) To carry out the following treatment, payment, or health care operations: (A) Use by the originator of the psychotherapy notes for treatment; (B) Use or disclosure by the Covered Entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or (C) Use or disclosure by the Covered Entity to defend itself in a legal action or other proceeding brought by the individual; and (ii) A use or disclosure that is required by the Secretary of HHS to investigate or determine our compliance or permitted by law; uses and disclosures for health oversight activities with respect to the oversight of the originator of the psychotherapy notes; sues and disclosures about decedents; or uses and disclosures to avert a serious threat to health or safety of a person or the public. *Psychotherapy notes* means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. *Psychotherapy notes* exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Marketing. We are required by law to receive your written authorization before we use or disclose your health information for marketing purposes, except if the communication is in the form of: (A) a face-to-face communication made by us to you; or (B) a promotional gift of nominal value we provide. If the marketing involves direct or indirect remuneration to us from a third party, the authorization must state that such remuneration is involved. If the marketing involves financial remuneration to us from a third party, the authorization must state that such remuneration is involved.

Sale of PHI. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization. Such authorization must state that the disclosure will result in remuneration to the Covered Entity.

Substance Use Disorder Treatment Records. We may not use or disclose substance use disorder treatment records received or maintained from substance use disorder treatment programs that are subject to 42 CFR Part 2, or testimony relaying the content of such records, in any civil, criminal, administrative, or legislative proceedings against you, unless: (1) you provide written consent; or (2) a court issues an order after notice and an opportunity to be heard are provided to you or the holder of the record, as required under 42 CFR Part 2. Any court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

You have the following rights regarding the medical information this office maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy your medical information with the exception of any psychotherapy notes. To inspect and copy your medical information, you must submit your request in writing to the HIPAA Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. For information regarding such a review contact the HIPAA Privacy Officer. If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to

another individual or entity. We may charge you a reasonable cost-based fee limited to the labor costs associated with transmitting the electronic health record.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by this office. To request an amendment, your request must be made in writing and submitted to the HIPAA Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a. Was not created by us;

b. Is not part of the medical information kept by this office;

c. Is not part of the information which you would be permitted to inspect and copy; or

d. Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures this office has made of your medical information. We are not required to list certain disclosures, including disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations; however, if these disclosures were made through an electronic health record, you have the right to request, beginning on dates established by law or regulation, an accounting for such disclosures that were made during the previous 3 years. To request this accounting of disclosures, you must submit your request in writing to the HIPAA Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure we make of your medical information. *We are not required to agree to your request for a restriction, except as noted below.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. We are required to agree to your request for a restriction if, except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment or health care operations (and is not for purposes of carrying out treatment) and the medical information pertains solely to a health care item or service for which we have been paid out of pocket in full. To request restrictions, you must make your request in writing to the HIPAA Privacy Officer.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in a certain manner. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the HIPAA Privacy Officer. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our website at the address listed below. To obtain a paper copy of this Notice, contact the office at (231) 269 - 4185.

Right to Receive Notice of Discovery of a Breach of Unsecured Protected Health Information. We are required to notify you of any breach of unsecured protected health information concerning you following the discovery of the breach when required by regulation.

REVISIONS TO THIS NOTICE:

We reserve the right to revise this Notice. Any revised Notice will be effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of any revised Notice in this office. Any revised Notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you visit the office we will offer you a copy of the current Notice in effect.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. To file a complaint with this office, contact:

HIPAA PRIVACY OFFICER (KEISHA SEXTON)
NORTHERN PINES HEALTH CENTER
11293 N M-37, SUITE A
BUCKLEY, MI 49620

Our website address is: www.northernpineshealthcenter.com

All complaints must be submitted in writing.

THIS OFFICE WILL NOT PENALIZE YOU IN ANY WAY FOR FILING A COMPLAINT.