Compass Orthopedics
AN AFFILIATE OF COMPASS REHABILITATION

1575 RAMBLEWOOD DRIVE
EAST LANSING, MI 48823

517-333-3777 (P)
517-203-3956 (F)

Welcome!

Thank you for choosing Compass Orthopedics, previously Mid Michigan Orthopaedic Institute, an affiliate of Compass Health.

Compass Orthopedic physicians have served the community since 1975, providing comprehensive services to treat the full range of foot, hand and knee injuries and diseases. Our Board-certified physicians take a holistic approach to your care, collaborating with you and your family to develop the best treatment plan for your situation. Our goal is simple: to provide our patients with exceptional care and exceptional service.

Attached are the new patient registration forms to be completed to schedule your appointment, along with some useful information about our practice.

If you have any questions or concerns, please do not hesitate to ask.

Hours

Monday thru Thursday	8:00AM to 5:00PM
Friday	8:00AM to 1:30PM
Saturday & Sunday	Closed

Cancellations

If unable to keep a scheduled appointment, please contact the office at least 24 hours in advance to avoid a $25 No-Show fee. If unable to keep a scheduled *procedure* appointment, the office must be notified at least 48 hours in advance to avoid a $100 No-Show Fee. These charges will be your responsibility and billed directly to you. Habitual no shows and/or cancels may result in being discharged from the practice.

Prescription Refills

Prescription refills should be requested 48-72 hours prior to last dose for processing. Allow 24 hours prior to contacting pharmacy after the request is placed with the office. No narcotic prescriptions are refilled on weekends.

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Accepted Payment

Payment is required at time of service. Compass Health accepts cash, check and credit card including Discover, AMEX, VISA and MasterCard credit/debit cards.

Imaging

In order for a physician to render a diagnosis, all completed imaging must be brought to the appointment. Imaging may consist of MRIs, X-rays, CTs or myelograms. EMG testing must also be provided. Failure to do so may result in the appointment being rescheduled. To request a copy of films, contact the hospital or diagnostic center where they were performed. Most require a 24-hour notice to prepare films for pickup.

Compass Imaging	517-999-5900	McLaren Greater Lansing Hospital	517-975-6382
Eaton Rapids Medical Center	517-663-9426	Michigan State University Radiology	517-353-5053
Sparrow Eaton Hospital	517-543-1050	Sparrow Hospital	517-253-6300

Website

The website provides information about our physicians, the ability to pay your bill, access to the patient portal and links to other Compass Health resources.

Patient Portal

The patient portal is available to manage your health online. It provides 24/7 access to your most recent health records and the ability to request appointments and refills for non-opioid prescriptions. Ask our staff how you can sign up.

Directions

From the 127 Expressway: Exit onto Lake Lansing Road and turn East, Turn South on Coolidge Road, Turn Right (West) onto Ramblewood Drive and then office is first building on the left, first floor.

Appointment Checklist

The following items must be submitted within 3 days of your appointment to avoid being rescheduled:

1. Completed Paperwork – submit via the mailing address or fax number indicated above, or email to: patient@mmoi.net.
2. Patient Portal Registration – follow the email instructions to set up your account using your 4-Digit Birth Year for the PIN. Under *Personal Health Record* select *Complete Visit Forms*.

Items to Bring to Your Appointment

Please plan to arrive 15 minutes early for your appointment with the following required items. Failure to do so will result in your appointment being rescheduled.

Test Results – Hand Carry CDs/Films
Driver's License
Insurance Card

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DEMOGRAPHIC FORM

Patient Name: _____ DOB:_____

Sex: _____Social Security Number: _____ Marital Status:_____

Address: _____

City: _____ State: _____ Zip Code:_____

Telephone – Home: _____Work: _____ Cell:_____

By providing your cell phone number, you consent to receiving appointment reminders and important calls via prerecorded message.

☐ I Do ☐ I Do Not authorize Compass Health to leave detailed messages on voicemail.

Email: _____

Preferred Method of Contact: ☐ Phone ☐ Mail ☐ Email

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White
☐ Hawaiian or Pacific Islander ☐ Other (please list) _____

Ethnic Group: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other (please list) _____

Preferred Language: ☐ English ☐ Spanish ☐ Other (please list) _____

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Spouse/Partner Name: _____ Spouse/Partner Employer: _____

Parent or Legal Guardian (if patient is dependent/minor): _____

Address (if different from patient): _____

City, State, Zip Code: _____

Emergency Contact Not Living with You: _____

Relationship to Patient: _____ Telephone: _____

Is This Visit Related to Any of the Following? ☐ Work Injury ☐ Auto Accident ☐ Other Incident

Please Explain: _____

If yes, date of injury: _____ ☐ My problem did not result from an accident.

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NEW PATIENT INFORMATION

Patient Name: _____ Age:_____ Date of Birth:_____ Sex: ____

Height: _____ Weight:_____ Pharmacy: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

CHIEF COMPLAINT

Symptoms or problem that led to today's visit: _____

_____

How did your problem start? _____ Date: _____

Current problem is a result of: (check all that apply and list date of injury)

☐ Car Accident ☐ Work Accident ☐ Not an Accident ☐ Other: _____ Date of Injury: _____

Studies / Tests Completed (check box and enter date)

☐ X-rays _____
☐ Angiogram _____
☐ Myelogram _____
☐ Nerve Block _____
☐ Shunt Study _____
☐ MRI _____
☐ CT Scan _____
☐ EMG _____
☐ Discogram _____
☐ Other (specify) _____

Treatments

Physical Therapy	☐ Yes	☐ No	Did it help?	☐ Yes	☐ No
Chiropractic Manipulation	☐ Yes	☐ No	Did it help?	☐ Yes	☐ No
Treatment at Pain Clinic	☐ Yes	☐ No	Did it help?	☐ Yes	☐ No

Surgeries & Hospitalizations	Year	Complications

Current Medications	Dose	Frequency

Allergies to Medications:

Any problems with anesthesia? ☐ Yes ☐ No

Have you ever been diagnosed with an antibiotic resistant infection such as MRSA or VRE? ☐ Yes ☐ No

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MEDICAL FORM

Patient Name: _____ DOB:_____

Joint(s) being seen for today: ☐ Hand ☐ Knee ☐ Ankle ☐ Foot ☐ Upper Leg ☐ Lower Leg

Side: ☐ Right ☐ Left ☐ Bilateral ☐ Other (please explain) _____

Major Complaint (circle all that apply):

Grinding Instability/Giving Away Locking Mass Numbness Pain Stiffness Swelling

Other (please explain):_____

Location: ☐ Front ☐ Back ☐ Inner Side ☐ Outer Side ☐ All Over ☐ Deep Inside

Onset of Problem / Date: _____

☐ Gradually ☐ Suddenly ☐ Auto Injury ☐ Home Injury ☐ Work Injury ☐ Sport Injury ☐ Don't Know

Sensation/Limitations: (if applicable)

☐ Feels Unstable ☐ Felt a Pop ☐ Felt a Sharp Pain ☐ Heard a Pop ☐ Cannot Bear Weight

Other (please explain): _____

Swelling: ☐Did not Swell ☐Swell Immediately ☐Swelled Next Day ☐Swell within Few Hours

Problem Aggravated By (circle all that apply):

Exercise Stairs Running Sports Standing Walking Work Activities Other

Problem Relieved By (circle all that apply):

Elevation Heat Ice Injections No Relief NSAIDS Pain Meds Therapy Rest

Pain: ☐ None ☐ Mild ☐ Moderate ☐ Severe Scale 1-10: _____

Walking Distance: ☐ Less than 1 block ☐ 1-3 blocks ☐ 4-6 blocks ☐ greater than 6 blocks

Walking Difficulty: (stairs/ladders/inclines/or uneven): ☐ None ☐ Some difficulty ☐ Severe

Functional Limitations:

☐ None ☐ Limited Recreational Activity ☐ Limited Daily & Recreational Activities ☐ Severe

Ambulatory Device Required: ☐ Yes ☐ No

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PQRS REPORTING

In accordance with U.S. Congressional laws, the following information must be obtained on a yearly basis to receive payment for our services.

Patient Name: _____ Date of Birth: _____

Today's Physician: _____ Date: _____

1. Age 21-64, have you received a Pap Test to screen for cervical cancer? ☐ Yes ☐ No ☐ N/A
   If yes, when? _____
2. Age 42-69, have you received a Mammogram in the last 27 months? ☐ Yes ☐ No ☐ N/A
   If yes, when? _____
3. Have you received a yearly Influenza (flu) Vaccination since Aug. 1, 2019? ☐ Yes ☐ No
   If yes, when? _____
4. Age 65 years and older – have you received a Pneumonia Vaccination? ☐ Yes ☐ No ☐ N/A
   If yes, when? _____
5. Are you a tobacco user?
   - ☐ Yes Amount per day _____ for _____ years.
   - ☐ No I have never used tobacco.
   - ☐ No I quit ____ years ago. At that time, I used tobacco ____ times per day for ____ years.
6. Please list your current or changes to your medications:
   - ☐ No Changes
   - ☐ See List Provided

- _____
- _____
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- _____
- _____
- _____

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INSURANCE INFORMATION

INSURANCE COMPANY: _____ Primary Insurance: ☐Yes ☐ No

Address: _____

City, State, Zip Code: _____

Contract Number: _____ Group Number: _____

Subscriber: _____ Date of Birth: _____

Relationship to Patient: _____

OTHER INSURANCE: _____

Address: _____

City, State, Zip Code: _____

Contract Number: _____ Group Number: _____

Subscriber: _____ Date of Birth: _____

Relationship to Patient: _____

WORKMAN'S COMP OR AUTO

Employer of Subscriber (if different from above): _____

Address of Employer (if different from above): _____

Claim #: _____ Adjuster: _____ Telephone: _____

MEDICARE:

Medicare Number: _____ Are you or your spouse employed? ☐Yes ☐No

What is the basis for the patient's entitlement to Medicare?

☐ Age ☐ Disability ☐ Renal Disease ☐ Other (Explain) _____

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FINANCIAL POLICY

The following policies address questions regarding patient and insurance responsibility for services rendered:

INSURANCE. Most insurance plans participate with Compass Health. If you are not insured by an accepted plan, payment is due at time of service. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

CO-PAYMENTS, CO-INSURANCE and DEDUCTIBLES. All co-payments, co-insurance and deductible amounts must be paid at the time of service. This arrangement is part of your contract with your insurance company. We accept cash, check, and credit card payments in the office. A $10.00 statement fee will be assessed if you do not pay at time of service.

PROOF OF INSURANCE. Driver's license and valid insurance must be on file to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be held responsible for the balance of claim.

CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. However, your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

WORKER'S COMP OR AUTO-RELATED INJURY. You must provide the claim/file number and the name of the adjustor prior to your appointment to ensure proper billing of claims. Failure to notify us may result in you being responsible to pay for services in full.

COVERAGE CHANGES. If your insurance changes, you must notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Failure to notify us may result in you being responsible to pay for services in full.

NONPAYMENT. Accounts 90 days past due may be referred to a collection agency and patient discharged from the practice. At that point, physicians would be able to provide treatment on an emergency basis only for 30 days.

NON-SUFFICIENT FUNDS. A $25.00 NSF fee will be assessed for any payments not honored by your banking or credit card institution.

CREDIT CARD ON FILE: To provide a convenient way to pay bills and address uncertainties due to insurance coverage, a credit card authorization on file is required to pay any outstanding balances for services rendered and determined to be the responsibility of the patient, parent and/or legal guardian. A monthly invoice is emailed prior to the charge being applied. This information is kept in a secure and protected file and authorization may be revoked at any time. If a credit card is not available, a retainer of $500 is accepted and would require replenishment upon the balance reaching $250 or less.

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AUTHORIZATION FOR MEDICAL TREATMENT

INIT. _____ I consent to receiving services at Lansing Neurosurgery, which may include diagnostic procedures and treatment by my physician, his assistant, designees or consultants, as may be necessary in the judgment of my physician. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care.

AUTHORIZATION OF RELEASE OF INFORMATION

INIT. _____ I authorize Compass Health to transfer clinical information about me to other healthcare providers/agencies as needed to carry out my treatment/plan of care. Medical information will not be disclosed for any reason except treatment, payment or healthcare operations, unless you provide written consent.

I authorize Compass Health to release information about my healthcare to the following individuals. Written authorization is valid for one year and may be revoked in writing at any time, but such revocation will not affect any prior authorized uses of disclosures.

Name:_____Relationship:_____

Name:_____Relationship:_____

AUTHORIZATION TO PARTICIPATE IN TELEHEALTH CONSULTATIONS

INIT. _____ I have received the Telehealth Consultation information advising of potential benefits and/or risks of telemedicine. I understand it is a treatment option and that I may withdraw consent at any time without affecting my right for future care or treatment.

PATIENT CENTERED MEDICAL HOME - NEIGHBORHOOD

INIT. _____ I have received the Patient Centered Medical Home – Neighborhood brochure describing the model of care, what I can expect from my physician and what is expected of me.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

INIT. _____ I acknowledge that I have been offered the Compass Health Notice of Privacy Practices.

AUTHORIZATION FOR PAYMENT

INIT. _____ I request payment of authorized insurance benefits made either to me or on my behalf to Compass Health for any services furnished to me by them. I authorize the holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits for related services. I understand that Compass Health will bill my insurance company, but that I am responsible for any balance not paid by insurance as well as any coinsurance, copayments and/or deductibles, that I am ultimately responsible for payment of services that are rendered to me.

AUTHORIZATION FOR CREDIT CARD ON FILE

INIT. _____ I authorize Lansing Neurosurgery to charge my credit card up to $600 per month for any balance of charges not paid by insurer. My card will be charged in the event there is an outstanding balance due after the bill has been submitted to my insurance company for reimbursement have been processed.

PATIENT/LEGAL GUARDIAN PRINTED NAME: _____ DATE: _____

PATIENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

EMAIL: _____ DATE: _____

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TELEHEALTH CONSULTATIONS ARE AN OPTION

This provides guidelines for participating in telemedicine or video conferencing services:

1. Purpose and Benefits The purpose of this service is to use telemedicine or video conferencing to enable patients to get medical care without the inconvenience and expense of traveling to a practice.

2. Nature of Telemedicine Consultation During the telemedicine consultation:

    a. Details of you and/or your medical history, examinations, x-rays and tests will be discussed with other health professionals through the use of interactive video, audio and telecommunication technology.

    b. Physical examination may take place.

    c. Nonmedical technical personnel may be present in the telemedicine office to aid in video transmission.

3. Medical Information and Records All existing laws regarding your access to medical information and copies of your medical records apply to telemedicine services. Additionally, dissemination of any patient-identifiable images or information from a telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

4. Confidentiality Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine services. All existing confidentiality protections under federal and Michigan State law apply to information disclosed during telemedicine or video service.

5. Risks and The Need for Further Evaluation Telemedicine services are similar to a standard medical office visit, except interactive video technology will allow you to communicate with a qualified provider of medical services remotely. The use of video technology to deliver healthcare and educational services is a newer technology and may not be equivalent to direct patient to provider contact.

6. Your Rights You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment. Revocation of this consent does not create a risk, loss of, or withdrawal of any program benefits for which you would otherwise be entitled.

7. Changing to an In-Person Visit If at any time during your Telemedicine Consultation you wish to stop and request an in-person visit, you have that option to consult with a provider of medical services in person.

8. Financial Agreement This telemedicine consultation will be paid for by your insurance company. However, in the event they refuse payment you may be held finically responsible for any and/or all telemedicine services rendered to you.

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WHAT IS PATIENT CENTERED MEDICAL HOME – NEIGHBORHOOD?

A Patient Centered Medical Home Neighbor is a system of care that is focused on you, the patient. It is a partnership between you, your PCP and us. As your specialty doctor, we work within your healthcare team to provide all of your health needs. As part of your healthcare team, we are partnering with your PCP and coordinating your care. We are sharing the commitment to effectively and efficiently co-manage your care over time. As your specialist, we will be sharing limited or long-term management of your condition with your PCP. We will provide advice, guidance and periodic follow-up until your illness has stabilized or treatment has been completed.

WE TRUST YOU, OUR PATIENT, TO:	WE, AS YOUR PHYSICIAN & STAFF, WILL CONTINUE TO:
Tell us what you know about your health and illnesses.	Communicate with your primary care provider (PCP) regarding your care.
Tell us about your needs or concerns.	Provide your PCP with timely written reports of your tests and visits.
Take part in planning your care.	Notify your PCP of any cancelled or no-show appointments.
Follow the care plan that is agreed upon or let us know why you cannot so that we can try to help or change the plan.	Schedule timely appointments based on your needs.
Tell us what medications (prescribed or over the counter) you are taking.	Listen to your feelings and questions to aid in informed decision making.
Let us know when you see other doctors and what medications they put you on or change.	Create and explain care plans that best fit your disease, treatment and wishes.
If referred by one of our physicians for additional testing or consults, please request the office send us a report about your care when you see them.	Care for you by using evidence-based medicine and best practice recommendations.
Learn about your insurance so you know what it covers.	Coordinator and schedule care with trusted experts when additional care is needed.
Keep your appointments or notify us of your cancellation within 24 to 48 hours.	Notify your PCP of any additional care or referrals needed.
Give us feedback so we can improve our services.	Be available for phone consultations with your PCP.

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. **Please review it carefully.**

Protected health information, about you, is maintained as a record of your contacts or visits for healthcare services with our practice. Specifically, "protected health information" is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related health care services. Our practice is required to follow specific rules to maintain the confidentiality of your protected health information, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow applicable rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. A copy of a revised Notice of Privacy Practices may be obtained by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. If you have any questions about this Notice, please contact our Privacy Manager at 517-999-5900.

Your Rights Under The Privacy Rule
Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

- **You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices -** We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.
- **You have the right to authorize other use and disclosure -** This means you have the right to authorize or deny any other use or disclosure of protected health information that is not specified within this notice. You may revoke an authorization, at any time, in writing, except to the extent that your Healthcare Provider or our office has taken an action in reliance on the use or disclosure indicated in the authorization.
- **You have the right to designate a personal representative –** This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.
- **You have the right to inspect and copy your protected health information -** This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. We have the right to charge a reasonable fee for copies as established by professional, state, or federal guidelines.
- **You have the right to request a restriction of your protected health information -** This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases, we may deny your request for a restriction.
- **You may have the right to request an amendment to your protected health information -** This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.
- **You have the right to request a disclosure accountability -** This means that you may request a listing of disclosures that we have made, of your protected health information, to entities or persons outside of our office.

How We May Use or Disclose Protected Health Information
Following are examples of uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

- **Treatment -** We may use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other Healthcare Providers who may be involved in your care and treatment. We may also call you by name in the waiting room when your Healthcare Provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health related benefits and services offered by our office.
- **Payment -** Your protected health information will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare 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.

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- **Healthcare Operations -** We may use or disclose, as-needed, your protected health information in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services , and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance-related activities. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

Other Permitted and Required Uses and Disclosures
We may also use and disclose your protected health information in the following instances as outlined below. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

- **To 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, that you identify, your protected health information that directly relates to that person's involvement in your healthcare. 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 protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your Healthcare Provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your healthcare will be disclosed.
- **As Required By Law -** We may use or disclose your protected health information to the extent that is required by law.
- **For 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.
- **For 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.
- **For Health Oversight -** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
- **In Cases of 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. In this case, the disclosure will be made in a manner that is consistent with the requirements of applicable federal and state laws.
- **To The 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, to monitor product defects or problems, to report biologic product deviations, to track products, to enable product recalls, to make repairs or replacements, or to conduct post-marketing surveillance, as required. **For Legal Proceedings -** We may disclose 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.
- **To Law Enforcement -** We may also disclose protected health information, as long as applicable legal requirements are met, for law enforcement purposes.
- T**o Coroners, Funeral Directors, and Organ Donation -** We may disclose 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 his/her duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
- **For Research -** We may disclose your protected health information to researchers when an institutional review board has reviewed and approved the research proposal and established protocols to ensure the privacy of your protected health information.
- **In Cases of 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.
- **For 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 service.
- **For Workers' Compensation -** Your protected health information may be disclosed as authorized to comply with workers' compensation laws and other similar legally-established programs.
- **When an Inmate -** We may use or disclose your protected health information if you are an inmate of a correctional facility and your Healthcare Provider 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 about you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

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 Manager of your complaint.