American Health Network
Part of Optum®

bone & spine

Brian P. Murphy, MD, MS
Board certified American Academy of Orthopaedic Surgeons

Joni Laser, PA-C

Welcome to American Health Network Bone & Spine

☐ **AVON**
8607 East U.S. 36
#100
Avon, IN 46123

☐ **CARMEL**
12174 N. Meridian St.
Suite 100
Carmel, IN 46032

☐ **FRANKLIN**
990 East State Road 44
Franklin, IN 46131

☐ **INDIANAPOLIS**
7151 Marsh Road
#100
Indianapolis, IN 46278

Dear New Patient:

We would like to take this opportunity to welcome you to our practice and thank you for entrusting us with your medical care. We want to share with you some information about our standard processes that we hope will be helpful to you throughout your care.

Phone Hours

In order to most efficiently handle patient care, we utilize a centralized call center. Our call center hours are Monday-Friday 8:00 am to 4:30 pm. Our phone number is (317)208-3866. If you have an urgent medical need outside of our normal business hours, the provider on call can be reached by calling our office; the answering service will contact the provider on call and have them call you.

Refill Requests

Please allow 72 hours for your refill request to be processed. Our office will call you when your prescription is ready to be picked up from our office. Please bring your photo ID with you to pick up prescription.

FMLA & Disability Paperwork

In order for us to accurately and thoroughly complete your paperwork for FMLA and/or disability, please allow us 14 business days to complete this paperwork. If for some reason you have waited longer than 14 business days, please contact our office to inquire about the status of your paperwork.

AHN Bone & Spine will charge a one-time fee of $25 for FMLA/Disability paperwork per episode of care. Please note, additional fees that may be billed are:

- returned checks $25;
- copying of medical records (fees are set by Indiana statute; amount varies based on number of pages).

Arrival Time

If you have recent X-Rays please arrive **15 minutes early** and bring your paperwork along with your current insurance card(s). If you DO NOT have recent X-Rays please arrive **30 minutes early** for X-Rays and registration. **If you have had any recent X-rays, MRIs, or CT scans pertaining to your visit with us you are responsible for bringing the images to your appointment.** You will also be asked to show your picture ID (driver's license, student ID card, Indiana ID card.) Anyone under the age of 18 years old must have a parent (or guardian) present. Also if you are under the age of 18 without a picture ID you parent (or guardian) must present their picture ID at the visit.

Insurance Card(s)

Please be prepared to present your insurance card(s) and pay any co-pay at each visit. Co-pays may be paid by cash, check, or credit card. We accept most credit cards and also accept Health Savings Account (HSA) cards. If you do not have insurance, we require a minimum payment of $100.00 at the time of the service for each office visit. If you do not have insurance and pay in full for all charges at the time of service, you'll receive a 15% discount.

If you have any questions regarding payment please contact our office in advance. Please check with your insurance provider to be sure they have your doctor listed.

Cancellations: Appointment & Surgery

If you are unable to make your appointment time please contact our office at least 24 hours in advance to reschedule or cancel. There will be a $250 fee for patient cancelling a surgery within 10 business days of the scheduled surgery. Three reschedules of the same surgery will be deemed as a cancellation.

Again, thank you for choosing American Health Network Bone & Spine for your health care needs. We look forward to treating you.

Sincerely,

Dr. Brian P. Murphy and Staff

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AMERICAN HEALTH NETWORK
MEDICAL HISTORY SCREENING FORM orthopaedics

Date: _____

Name: _____ Family Physician: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Hand Dominance (Right or Left): _____

Reason for Visit: _____

Email: _____

Physical Therapy: ☐ Yes ☐ No; If yes, how long? _____ Medication for Pain: _____

Have you had any of these treatments? ☐ Injection ☐ Brace ☐ Crutches

Have you ever had surgery for this problem? Yes No; If yes, surgery date(s)/Physician(s)/Procedure(s):

_____

Are you currently under the care of a Pain Management physician? ☐ Yes ☐ No; If yes, Who? _____

Location of Pain: _____ Duration of Pain: _____ Work Related? _____

Did pain begin after a specific activity/injury? _____ ☐ Gradual ☐ Sudden Date/Length of injury: _____

Injury was due to: ☐ Sport/Exercise:(type) _____ ☐ Auto Accident ☐ Work Related ☐ Other: _____

Explain injury: _____

What activities worsen pain? _____

What activities improve pain? _____

Have you noted any arm or leg weakness/numbness? _____

Pain Scale *(circle one)*: 0 (No Pain), 1 2 (Mild), 3 4 5 6 7 (Moderate), 8 9 10 (Severe)

Your pain is: ☐ Constant ☐ Intermittent Does your pain wake you from your sleep? ☐ Yes ☐ No

What best describes your pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

What makes your symptoms worse? _____

☐ Standing ☐ Walking ☐ Running ☐ Getting Up Stairs ☐ Twisting ☐ Kneeling ☐ Squatting ☐ Lifting ☐ Reaching ☐ Gripping

If you are having knee pain: ☐ Catching ☐ Instability ☐ Swelling

Since your problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged

ANY RECENT IMAGING (with Dates and Location of Imaging)

Xray: _____

CT Scan: _____

MRI: _____

EMG/NCV: _____

CT Myelogram: _____

Bone Scan: _____

Other: _____

REVIEW OF SYSTEMS

- ☐ Fever
- ☐ Fatigue
- ☐ Loss of Appetite
- ☐ Current Illness
- ☐ Sleep Apnea
- ☐ Shortness of Breath
- ☐ Pneumonia
- ☐ Wheezing
- ☐ Arthritis
- ☐ Poor Balance
- ☐ Joint Pain
- ☐ Stiffness
- ☐ Numbness
- ☐ Swelling
- ☐ Deformities
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gerd
- ☐ Ulcers
- ☐ Nausea
- ☐ Vomitting
- ☐ Bladder Infection
- ☐ Kidney Disease
- ☐ Retention
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Clotting Disorder/Blood Clots
- ☐ Strokes
- ☐ TIA's
- ☐ Epilepsy
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ MRSA History
- ☐ Latex Allergy

PAST MAJOR MEDICAL HISTORY

- ☐ Aids
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blood Clots/DVT
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Gerd/Reflux
- ☐ HIV
- ☐ Gout
- ☐ Heart Attack when: _____
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Osteoarthritis
- ☐ Respiratory Issues
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Strokes/TIA's
- ☐ Thyroid Disorder
- ☐ Ulcers (Stomach)
- ☐ Other:

_____

_____

_____

PAST MAJOR SURGICAL HISTORY

- ☐ Back or Neck Surgery (Fusions, Etc.)
- ☐ Other _____
- ☐ CABG (Coronary Bypass) when: _____
- ☐ Gastric Bypass
- ☐ Pacemaker
- ☐ Stents
- ☐ None
- ☐ Arthroscopy
- ☐ Joint Replacement by who/what/when:

_____

☐ Other:

_____

ALLERGIES

_____

_____

_____

_____

FAMILY HISTORY

(i.e., high blood pressure, diabetes, etc.)

_____

_____

_____

_____

_____

SOCIAL HISTORY

Occupation:

_____

_____

- ☐ Currently Working
- ☐ Retired
- ☐ Disabled
- ☐ Unemployed

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Alcohol:

☐ Yes ☐ No

If yes, how much:

_____

Illegal Drug Use:

☐ Yes ☐ No

If yes, drug:

_____

Tobacco:

☐ Yes ☐ Chew ☐ Cigarettes

Packs/Cans Per Day:

_____

How Many Years:

_____

☐ No

☐ Quit (when) _____

PLEASE LIST ALL MEDICATIONS AND DOSAGES (Prescription and Over-the-Counter)

If your PCP is an AHN Provider you do not need to list meds.

_____

_____

_____

_____

_____

IF YOU ARE CURRENTLY SEEING A CARDIOLOGIST - PLEASE LIST THEIR NAME HERE: _____

LIST ANY OTHER SPECIALISTS YOU ARE SEEING: _____

_____

Are you currently receiving or plan to apply for: ☐ Workmen's Comp ☐ Unemployment ☐ *FMLA/STD

* A $40 fee will be charged accordingly for any FMLA or Short Term Disability paperwork submitted to us by you or your employer.

I HAVE RECEIVED A COPY OF THE BONE & SPINE WELCOME LETTER AND AGREE TO PAY CHARGES AS INDICATED:

Patient Signature: _____ Date: _____

American Health Network

215 Patient/Guardian Authorizations to Disclose Protected Health Information to Others

Patient Name:_____ DOB:_____ Today's Date: _____

Primary Care Provider & Location:_____

To the patient: American Health Network will attempt to follow your instructions to the extent the healthcare provider believes such disclosure will not interfere with your treatment. This form will be used at all AHN locations. Please note that AHN does not need specific authorization to disclose information for treatment, operations or payment purposes consistent with its Notice of Privacy Practices.

Authorization by: ☐ Patient ☐ Legal Guardian (name): _____

American Health Network may disclose all of my Protected Health Information* (*including that about alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS, or information related to psychiatric treatment or counseling, and related to communicable disease, unless I limit below*) to:

	Name	Relationship	Contact info (phone/address)	NextMD Access Y/N
1				
2				
3				

*** Limitation - The following Information may NOT be disclosed to any of the above**:

_____

_____

_____

Duration/Expiration: ONLY the most recent signed DISCLOSURE AUTHORIZATION will be honored. This Authorization will stay in effect during my treatment at AHN unless it is revoked/revised by me in writing. I agree that AHN is not responsible for information that might be re-disclosed by those persons who I have authorized to receive information.

Patient/Guardian Signature:_____

Date: _____

Provide copy to the patient at his/her request.

_____

American Health Network
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Patient information

Chart #

Patient last name	First name, MI	Date of birth	SSN

Home address (include Apt #)
Street City, State, ZIP

Sex	Marital status	Phone
M F	S M W D Sep	Home ( ) Work ( ) Cell ( )

Employment status	Employer name and address (if student, name of school)
☐ Full time ☐ Part-ime ☐ FT student ☐ PT student ☐ Retired	

Primary care physician (PCP) PCP phone City and state

Legal guardian (if patient is under age 18) Relationship	Referring physician (if different than PCP) City, State

Emergency contact (outside of home)
Name Relationship Phone

Alternate contact (name and phone or email; initials of parent/legal guardian if patient is a minor)

PRIMARY INSURANCE INFORMATION

Primary insurance company	Member/policy #	Group #	Effective date

Policy holder name (if other than self)	Policy holder DOB (If other than self)	Policy holder SSN (if other than self)

Relationship to patient (if other than self)	Policy holder employer (if other than self)	Policy holder employer phone #

Claims address (if insurance card was not provided)

SECONDARY INSURANCE INFORMATION

Secondary insurance company	Member/policy #	Group #	Effective date

Policy holder name (if other than self)	Policy holder DOB (If other than self)	Policy holder SSN (if other than self)

Relationship to patient (if other than self)	Policy holder employer (if other than self)	Policy holder employer phone

Claims address (if insurance card was not provided)

I UNDERSTAND THAT AMERICAN HEALTH NETWORK WILL USE MY HOME ADDRESS/PHONE # TO LEAVE MESSAGES REGARDING TEST RESULTS, APPOINTMENTS, ETC., UNLESS I REQUEST THAT THE FOLLOWING ALTERNATIVE CONTACT BE USED (FOR EXAMPLE, CELL # OF FAMILY MEMBER/FAMILY):

I REQUEST/AUTHORIZE AMERICAN HEALTH NETWORK TO FURNISH THE MEDICAL CARE THAT IS NECESSARY FOR MY CONDITION, BUT I ACKNOWLEDGE THAT NO GUARANTEES AS TO THE RESULTS HAVE BEEN MADE TO ME. I WAS PROVIDED A COPY OF THE PRIVACY NOTICE AND PATIENT FINANCIAL POLICIES (INCLUDING THE MEDICARE AGREEMENT IF APPLICABLE). I HAVE READ, UNDERSTOOD AND HAD THE OPPORTUNITY TO ASK QUESTIONS AND I AGREE TO ABIDE BY THESE TERMS.

Signature of patient/guardian _____ Printed name _____ Date _____

AHN notes

American Health Network
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American Health Network Patient Financial Policies, Terms & Conditions Effective 01-01-2018

Payment Guarantee: For services rendered by American Health Network ("AHN"), you guarantee payment of your account at the time services are provided for any & all costs that are not paid by an insurance carrier, government payer (including Medicaid), & other third party payer (together, referred to as "PAYER"), including if your PAYER denies a claim after first approving it.. You acknowledge that you will be responsible for paying AHN for items & services provided to your dependents under these Conditions whether or not you are listed as the "Responsible Party" on the Patient Data Sheet. The person listed as the "Responsible Party" on the Patient Data Sheet will also be responsible to AHN for payment. All charges incurred are your responsibility.

Out of Network Referrals: An out-of-network provider may be called upon to render health care items or services to a covered individual during the course of treatment. Out-of-network providers are not bound by the payment provisions that apply to health care items or services rendered by an in-network provider under a covered individual's health plan. You should contact your health plan before receiving health care items or services rendered by an out-of-network provider to obtain a list of in-network providers that may render the health care items or services, as well as additional resources. You understand that any out-of-network charges are your responsibility as determined by your PAYER.

Physician Investments: Be advised that AHN physicians may refer you to a health care entity (an organization or business that provides diagnostic, medical or surgical services, dental treatment or rehabilitative care), in which the physicians have a private/individual investment, including, but not limited to: American Health Network, Knox Diagnostic Imaging Center, LLC, Damon Dialysis, LLC, Eagle Highlands Surgery Center, LLC, Beltway Surgery Centers, LLC and various other surgery centers. Patients are advised that in each case they may choose to be referred to another health care entity. Your signature on the Patient Data Sheet acknowledges you have received notice of physician investment(s).

Assignment of Benefits: To the extent there is PAYER coverage for payment of services, you agree that all medical & related benefits PAID by PAYER will be irrevocably assigned to AHN on your behalf.

Billing Information: You agree to provide complete & accurate information & notify us of changes to any of your information (address, phone number, insurance). We will use reasonable efforts to submit claims to your PAYER & promptly provide you with our statements. If for any reason, amounts that you owe are not paid promptly, including if a statement is returned as undeliverable, you may be referred to a collection agency. Bring your government-issued photo identification & insurance cards to every visit. Otherwise, you may be required to pay in full that day.

Medicare Agreement: If you have Medicare coverage, you acknowledge that payment of benefits will be made to you or on your behalf for any items or services furnished to you by AHN (or the party who accepts assignment), including your physician services. You authorize any holder of medical or other information about you to release to Medicare & its agents, any information needed to determine these benefits or any benefits for related services.

Payment terms: We require payment at the time of your office visit. This includes amounts for co-pays, coinsurance, deductibles & past-due balances unless previous arrangements have been made with our billing department. If you fail to make payment at the time of service, we may charge extra processing fees in recognition of billing & collection expenses.

Billing Payers: We will file your claims with your PAYER after services are provided as a courtesy. If your PAYER pays you directly, you are responsible for payment in full to AHN. We may estimate what your PAYER will pay, but the PAYER decides your eligibility & benefits. It is your responsibility to understand what services are covered by your Payer. You will be fully responsible for paying for services or amounts that are not covered. Contact your PAYER before a service is provided if you have questions about coverage. You may request that we not file with your PAYER by completing required forms at the time the services are provided.

AHN will select the codes that are used in billing based on PAYER policies & industry standards. Payers make payment decisions based on the coverage policies for your insurance policy. Example: If you come in for a sports physical, AHN codes it as a sports physical. If your PAYER does not cover sports physicals, you will be responsible for paying. AHN cannot change the reason for the visit. It is your responsibility to know what your insurance covers.

The amount that your PAYER requires you to pay may depend on whether other providers bill separately for part of the service, for instance, where AHN takes the x-ray but someone else reads it. The amount you are required to pay may also depend on whether the service is preventative (i.e. you have no symptoms suggesting a problem) or diagnostic (i.e. you have symptoms). If you have a preventative screening scheduled, but show up at the appointment with symptoms, AHN usually needs to report it as diagnostic. This may result in you having to pay more, such as a higher co-insurance.

Your PAYER may require prior authorization or referral for some services. Obtaining authorization or referral does not guarantee that your PAYER will pay. You are responsible for ensuring that authorizations & referrals are obtained prior to obtaining services. Please call our Billing Department if you have difficulty with your PAYER, & we will try to assist.

You are responsible for payment until the account is paid in full. It may take time for AHN to resolve payment with your PAYER (i.e. processing delays, misplaced claims, requests for additional information & appeals). You are responsible for cooperating with requests for

additional information & assistance with appeals. AHN may wait until your PAYER officially notifies us of the amount that you owe or until disputes about how much your PAYER owes are resolved, before sending a statement to you. Payment is expected by the due date contained on our statements.
If AHN is contracted with your PAYER, the terms of that contract will be followed if there is a conflict between that contract & the terms of these Financial Policies & the terms of AHN's contract with your PAYER. If AHN is not contracted with your PAYER or AHN is unable to verify that your Payer will be responsible for payment, you may be required to pay in full at the visit.

Interest and Attorney's Fees: For any past due amounts, AHN shall be entitled to payment from you of interest at the rate of 1.5% per month (18% per annum), & you shall be responsible for all costs & expenses incurred in efforts to collect past due amounts from you, including interest charges, court costs, & reasonable attorney's fees. If a check is returned for insufficient funds, all charges incurred by AHN shall be your responsibility.

Note to parents of dependents: The Statement for your child will be sent to you, & you are responsible to AHN for prompt payment. You are responsible for paying AHN. If you believe that someone else is responsible for the child's medical expenses, you may take action against that person to recover the amounts for which they are responsible.

Workers Compensation Injury: If you believe you are being seen for an injury/illness as a result of your job, you need to provide written authorization from your employer to confirm this, & direction from your employer on who AHN should bill. If you do not provide this information at the time services are provided, AHN may bill you &/or your insurance company.

Self Pay Services: If you do not have insurance or if the services are not covered by your PAYER, you will receive a 15% discount for professional services rendered, when payment is made in full at the time services are rendered. This discount does not apply to amounts that you owe due to co-pays, coinsurance or deductibles.

Payment Options: If you are unable to meet your financial obligations, payment arrangements can be made. Financing options may be available. Contact our Billing Department to discuss payment options, before your account becomes overdue. In cases of financial hardship, ask about the practice's hardship policy. Hardship policies vary by practice; limitations & restrictions apply.

Making Payments: Patients generally may pay by cash, money order, check or personal credit card. This includes cards for "flexible spending accounts" &/or "health savings accounts". Card information may be kept on file by AHN to facilitate billing. If you have a credit balance, AHN may apply it to any outstanding balances on your account or the accounts of your dependents. Some locations may restrict payment by cash or check.

Fees Assessed by AHN: You may be charged fees for: (1) Returned Checks, (2) Completion of Forms (e.g. Disability or Family Medical Leave), (3) Copies of Medical Records, & (4) Failure to Cancel Appointments in Advance ("No Show"). Notify AHN of cancelations at least one business day in advance to avoid No Show fees. The No Show fee may be assessed up to the amount in our current Fee Schedule.

Termination of Services: If you fail to keep your account current or fail to respond to 3 notices to the address we have on file for you, you agree that AHN may terminate your relationship with any or all of its offices. In such event, you agree that you are no longer a patient, & AHN will not offer you a future appointment. You will have deemed yourself as terminating our relationship if you do not obtain services from AHN for 3 years or if you notify us that you will no longer be a patient. Acceptance back into the practice is at the discretion of AHN. AHN may terminate your relationship with us for other reasons, such as disruptive behavior or non-compliance with care plan, or for no reason.

Authorization to Release of Medical Information: The authorizations described in this Financial Policy may include records about infectious diseases & drug & alcohol abuse treatment. You authorize the release of information by AHN to third party payers (including insurance companies & their contractors), health care institutions, physicians & others involved in your medical care. You agree that as appropriate for your care, AHN may share information with family members & friends. You agree that AHN may provide your medical records to third party payers, review agencies, employers, welfare departments & others for treatment, payment or healthcare operations purposes.

AHN participates in one or more Health Information Exchanges. Healthcare providers can use these electronic networks to securely provide access to your health records for a better picture of your health needs. With this authorization, you agree that AHN, and other healthcare providers, may allow access to your health information through the Health Information Exchanges for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt out at any time by notifying an AHN Practice Manager or Compliance Officer. Your opt out notice needs to be in writing.

Accidents & Motor Vehicle Injuries: AHN's providers have the discretion to decide whether or not to see patients injured in motor vehicle accidents or for other liability injuries. AHN's providers also have discretion to decide whether or not to bill the liability insurance involved (i.e. home, auto, etc.). AHN does not have to agree to subrogate or accept liens. You must provide accurate information about the injury & may be required to complete an injury questionnaire. In all cases, you bear responsibility for the costs of your care & must pay them promptly at any time that location decides which may include requiring payment in full at time of service.
Continuing Agreement: I have read this information carefully & agree that everything in this Agreement applies to current & future health care services provided by AHN. I acknowledge that AHN may change these terms without notice to me.

Nondiscrimination Notice and Access to Communication Services

American Health Network does not discriminate on the basis of sex, age, race, color, national origin, or disability.

Free services are available to help you communicate with us. Such as, letters in other languages, or in other formats like large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free number 1-888-696-9637. TTY 711.

If you think you weren't treated fairly because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Optum Civil Rights Coordinator
11000 Optum Circle
Eden Prairie, MN 55344
Fax: 855-351-5495
Email: **Optum_Civil_Rights@Optum.com**

If you need help with your complaint, please call the toll-free number 1-888-696-9637. TTY 711. You must send the complaint within 60 days of when you found out about the issue.

You can also file a complaint with the U.S. Dept. of Health and Human services.
Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free **1-800-368-1019, 800-537-7697** (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

Language Assistance Services and Alternate Formats

This information is available in other formats like large print. To ask for another format, please call the toll-free number 1-888-696-9637. TTY 711.]

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 1-888-696-9637

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-888-696-9637

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：1-888-696-9637]。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-888-696-9637.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-696-9637 **번으로** 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-888-696-9637.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русскoм (Russian)**. Позвоните по номеру 1-888-696-9637.

1) نبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ [1-888-696-9637].

ATTENTION: Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-888-696-9637.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-888-696-9637.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-888-696-9637 an.

注意事項：**日本語 (Japanese)**
を話される場合、無料の言語支援サービスをご利用いただけます。1-888-696-9637 にお電話ください。

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं।
कृपया 1-888-696-9637 पर कॉल करें।

HUBACHISA: Kan ati dubbattu **Afaan Oromoo (Oromo)** yoo ta'ee, tajaajilliwwan gargaarsa afaanii, kanfalttii malee siif jira. Maaloo karaa 1-888-696-9637.

AADACHT: Wann du **Deitsch Schwetze (Pennsylvanian Dutch)** kann, kannscht du frei Schprooch aushilfe griege. Ruf Nummer 1-888-696-9637.

သတိထားပါ- သင့် **ဗမာစကား (Burmese)** ေျပာပါ ဟဆိုလွျင့်၊ ဘာသာစကားအကူအညီ ဝန်ေျဆာင်မှုမ ာား အခမဲ့ရရှိုင်သည်။ ေျက းဇူးျပီ၍ 1-888-696-9637ကို ေျခင့်ပါ။

OPGELET: Indien u **Nederlands (Dutch)** spreekt zijn taalbijstandsdiensten gratis voor u beschikbaar. Gelieve 1-888-696-9637 te bellen.

УВАГА: Якщо ви розмовляєте **українською мовою (Ukrainian)**, у вас є можливість скористатися безкоштовними послугами перекладача. Зателефонуйте, будь ласка, за номером 1-888-696-9637

ATENȚIE: Dacă vorbiți **românește (Romanian)**, vi se pun la dispoziție, în mod gratuit, servicii de traducere. Vă rugăm să sunați la 1-888-696-9637.

PROVIDER NOTICE OF PRIVACY PRACTICES

NOTICE FOR MEDICAL INFORMATION: Pages 4 - 10.

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.

Medical Information Privacy Notice

Effective January 1, 2019

We[1] are required by law to protect the privacy of your health information. We are also required to provide you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms “information” or “health information” in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, and if we maintain a website, we will post a copy of the revised notice on our website https://www.ahni.com/. If we maintain a physical delivery site, we will also post a copy in at our office. The notice will also be available upon request. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

How We Use or Disclose Information

[1] This Medical Information Notice of Privacy Practices applies to the following providers that are affiliated with Optum, Inc: American Health Network of Indiana, LLC; American Health Network of Ohio, LLC; American Health Network of Ohio Care Organization, LLC; Indiana Care Organization, LLC.

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to bill for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment.** We may use or disclose health information to obtain payment for health care services. For example, we may disclose your health information to your health plan in order to obtain payment for the medical services we provide to you. We may ask you for advance payment.

- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care. For example, we might analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, it is no longer subject to this notice and we may use it for any lawful purpose.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.

- **For Reminders.** We may use or disclose health information to send you reminders about your care, such as appointment reminders with providers who provide medical care to you or reminders related to medicines prescribed for you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.

- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.

- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.

- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.

- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers' compensation laws that govern job-related injuries or illness.

- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.

- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.

- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and permitted by law.

- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

    1. Alcohol and Substance Abuse
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases;
    5. Genetic Information
    6. HIV/AIDS

7. Mental Health
8. Minors Information
9. Prescriptions
10. Reproductive Health
11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out how to revoke an authorization, use the contact information below under the section titled “Exercising Your Rights.”

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction other than with respect to certain disclosures to health plans as further described in this notice.**
- **You have the right to request that we not send health information** to health plans in certain circumstances if the health information concerns a health care item or service for which you or a person on your behalf has paid us in full. We will agree to all requests meeting the above criteria and that are submitted in a timely manner.

- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests. In certain circumstances, we will accept your verbal request to receive confidential communications; however, we may also require you confirm your request in writing. In addition, any request to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as medical records and billing records. If we maintain a copy of your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect or obtain a copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as medical records and billing records if you believe the information is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on our website, https://www.ahni.com or by calling American Health Network Privacy Administrator at 317-580-6369.

Exercising Your Rights

- **Contacting your Provider.** If you have any questions about this notice or want information about exercising any of your rights, please call American Health Network Privacy Administrator at 317-580-6369 or you can send an email to ahn_privacy@ahni.com

- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

  Privacy Administrator
  10689 North Pennsylvania Street, Suite 200
  Indianapolis, IN 46280

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.