



SOUND HAND & ORTHOPEDICS

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION:

Patient Name: _____ DOB: _____

Please check all that apply:

May leave detailed voicemail at #(s): _____

May send email at address(es): _____

May leave a text message at #(s): _____

May leave information with family member(s): _____

May leave information with interpreter: _____

May send records to: _____

EMERGENCY CONTACT:

Name: _____

Phone #: _____

Relationship to Patient: _____

With this signature below I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change any information listed above.

Signature of Patient/ Authorized Consenter

Date

Patient/ Authorized Consenter Name

Authorized Consenter Relationship to Patient



TEXT MESSAGE ALERTS PRIVACY POLICY

Sound Hand & Orthopedics takes your privacy seriously, and we want you to know how we collect, use, and share your information when you opt-in for text messaging from our healthcare practice. For information on how we handle your Protected Health Information under applicable privacy laws (including for healthcare treatment and payment), please review our HIPAA Notice of Privacy Practices.

Information We Collect and Method of Collection

We collect personal information from you to send you text messages, including your name and phone number. We may also collect message interaction and consent data, including delivery status, response data, and method of opt-in. You provide your personal information to us when you contact us to make an appointment or if you are referred to our office, and our third-party service provider may collect message interaction data through their systems.

How We Use Your Information

We use your information to send you healthcare-related text messages, such as appointment reminders, text-to-pay links, mobile check-in links, and office closure announcements. We also use your information to monitor and improve our text messaging services. Under HIPAA, we may further use your name and phone number (along with other Protected Health Information) as explained in our HIPAA Notice of Privacy Practices.

Data Sharing and Disclosure

We do not sell or share the personal data collected under this policy with third parties or affiliates for marketing or promotional purposes without your prior explicit consent. Your text messaging opt-in is not shared with third parties except as required by law or with our trusted service providers as needed to provide the text messaging services. We may disclose your information as permitted by law for purposes of providing the services, legal compliance, corporate transactions (such as a merger or sale), or for security and safety (to prevent harm or to respond to an emergency).



How We Collect Consent

Your consent for us to send you text messages applies only to communications from our medical office and service partners and does not extend to third-party businesses. We collect your consent to receive text messages in three different ways:

Verbal Opt-In	<p>When you call our office to make an appointment, we may collect your consent verbally as shown in this example:</p> <p>Doctor's Office Staff: We can send you automated texts about your healthcare, including appointment reminders, text-to-pay, and office closures. Message and data rates may apply, depending on your cell phone service plan. You can opt out at any time by replying STOP. Would you like to receive these texts?</p> <p>Patient: Yes, please</p> <p>Doctor's Office Staff: Great! We will confirm your enrollment.</p> <p>(If you say "no," we will not enroll you to receive text messages.)</p>
Healthcare Opt-In	<p>The Federal Communications Commission has determined that when you as a patient give your number to a healthcare provider, the provision of your own phone number constitutes "prior express consent for healthcare calls" and text messages from that provider, such as appointment reminders. See 30 FCC Rcd 7961, ¶ 141 (2015). If you provide your phone number to us, we may rely on that as your prior express consent to receive text messages in accordance with applicable law. You can opt out at any time by replying STOP.</p>
Paper Opt-In	<p>In our patient paperwork, we may ask you to provide written consent to receive communications from us. This paper form will include language like the following: By supplying my home telephone number, mobile telephone number, email address, or other personal contact information, I consent to this medical office calling, texting, and contacting me at the information provided, for the purpose of notifying me of a pending appointment, a missed appointment, an overdue wellness exam, balances due, lab results, and any other healthcare treatment, payment or administrative matter. I consent to receiving multiple such messages per day. I understand and acknowledge that the mobile phone carrier or other companies providing my telecommunications services may charge me fees for such calls and text messages. I understand that text messages are unencrypted and there is a risk that text messages could be read by an unintended third-party while in transmission to me. This medical practice and its subcontractors are not responsible for any unauthorized access to my information while in transmission to me. I acknowledge this risk and still consent to receiving the messages described above. I understand that I may cancel this consent and opt out of receiving such communications by responding accordingly to such messages or notifying the medical office.</p>



Opt-Out Instructions

You can opt out of our text service at any time by calling our office or replying with "STOP" to any message you receive from us. Once you opt out, you will promptly stop receiving further messages unless you opt back in.

Security of Your Information

We take reasonable measures to protect the information you provide from unauthorized access, disclosure, or misuse. However, no system is completely secure, and we do not guarantee the security of your data during transmission or storage. Please also be aware that SMS text messages are not encrypted and the content may be accessible by third parties. We do not recommend sending sensitive information through SMS text message.

Changes to this Policy

We reserve the right to update or modify this Text Messaging Privacy Policy at any time. Any significant changes will be communicated via text message or other method as we determine appropriate. Continued use of our text service after any changes indicates your acceptance of the revised policy. If anything in this policy is inconsistent with our HIPAA Notice of Privacy Practices, the HIPAA Notice of Privacy Practices will control if it applies.

Contact Us

If you have any questions about this Text Messaging Privacy Policy or wish to update your text preferences, please contact our office.

I have read, and accept the privacy policy terms outlined above. With this signature below I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing.

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SOUND HAND & ORTHOPEDICS

Credit Policy

Thank you for selecting Sound Hand and Orthopedics for your health care needs. In order to effectively bill and collect on charges incurred at our practice, we require all patients to read and sign this credit policy. By signing this document, you agree to adhere to the policies detailed herein. The purpose of these guidelines is to clarify standards and expectations for both the office and our patients. Thank you for your cooperation.

Patient Responsibility: As a courtesy, Sound Hand and Orthopedics will bill on behalf of our patients to all healthcare plans with which we are contracted; however, it is the responsibility of the patient and/or guarantor to verify whether or not Rajiv Goel M.D. is contracted under their individual plan and to be aware of the specific benefit exclusions or limitations of said plan. Please contact your Member Services Department for clarification on coverage. In addition to this credit policy, Sound Hand and Orthopedics may require patients to sign additional waivers/disclaimers stating that you assume financial responsibility for services rendered at your request.

Payment Responsibility: For each visit, patient and/or guarantor are required to bring photo identification, their current insurance card(s), and applicable co-payment. Due to rapidly changing coverage and identification numbers, as well as to ensure correct billing, a **current insurance card is required to be presented at each visit**. Co-pays and deductibles are due and payable at time of service unless arrangements have been made with our business office.

Patients who are self-pay will receive a discount on clinic charges if their visit is paid in full at the time of service. Patient and/or guarantor assume responsibility for all charges and unpaid balances resulting from treatment provided by Sound Hand and Orthopedics. Payment for service(s) is due within 30 days of the first statement. If you are unable to pay the balance in full within 30 days, please contact our business office to make payment arrangements.

Insurance reimbursement is a contract between you and your carrier. If payment has not been received after 60 days from the time of service, please contact your carrier to check on the status of your claim and immediately contact the business office if matters are not in order. Delinquent accounts more than 60 days past due with no payments and/or defaulted payment arrangements are subject to review and possible collection action. A \$30.00 fee will be charged if your check is returned from your bank unpaid.

Cancellation Policy: Patients who are unable to keep their appointment should call at least 24 hours in advance to notify scheduling. Patients who fail to provide 24 hour cancellation notice and/or do not show up for scheduled appointments with Sound Hand and Orthopedics will be charged \$100 deposit to reschedule another appointment. This will be credited towards patient balance as long as they do not cancel again. A second cancellation will forfeit the deposit.

It is not our intention to cause undue hardship; however we must collect our receivables as efficiently as possible in order to continue our service to the community.

I have read, and accept the credit policy terms outlined above. I understand that I am ultimately financially responsible for payment of my account with Sound Hand and Orthopedics. I agree that in the event additional costs and/or fees are incurred in connection with the collection of my account, I understand that I am responsible for such charges.

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SOUND HAND & ORTHOPEDICS

PRIVACY POLICY FOR SOUND HAND & ORTHOPEDICS

Effective Date: January 1, 2013

1. Introduction

Sound Hand & Orthopedics ("we," "our," or "us") is committed to protecting the privacy of your personal health information (PHI). This Privacy Policy outlines how we collect, use, and protect your PHI in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Washington State law.

2. Information We Collect

We collect the following types of information:

Personal Health Information (PHI)

This includes any information about your health status, medical history, diagnosis, treatment, and related health services.

Personal Identification Information: This includes your name, address, phone number, Social Security number, and insurance information.

Payment Information: This includes credit card numbers, bank account information, and other payment details.

3. How We Use Your Information

We use your PHI for the following purposes:

Treatment: To provide, coordinate, or manage your healthcare and related services.

Payment: To obtain payment for services provided to you.

Healthcare Operations: To support the operation of our practice, including quality assessments, employee reviews, training, and licensing.

4. Disclosure of Your Information

We may disclose your PHI in the following circumstances:

To You: You have the right to access your PHI. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail, short message service (SMS), and paper mail.

To Healthcare Providers: We may share your PHI with other healthcare professionals involved in your care.

To Insurance Companies: We may disclose PHI to obtain payment for services provided.

For Legal and Regulatory Requirements: We may disclose PHI as required by law, including to public health authorities, law enforcement, and legal proceedings.

5. Your Rights

Under HIPAA and Washington State law, you have the following rights:

Right to Access: You can request a copy of your PHI.



Right to Amend: You can request corrections to your PHI.

Right to Restrict Disclosures: You can request limitations on how your PHI is used or disclosed.

Right to Confidential Communications: You can request that we communicate with you in a specific manner or at a certain location.

Right to an Accounting of Disclosures: You can request a list of certain disclosures of your PHI made by us.

6. Security Measures

We implement the following security measures to protect your PHI:

Physical Safeguards: Secure facilities and equipment.

Technical Safeguards: Encryption, firewalls, and secure passwords.

Administrative Safeguards: Staff training and access controls.

7. Changes to This Privacy Policy

We may update this Privacy Policy from time to time. Any changes will be posted on our website, and the effective date will be updated.

8. Contact Information

If you have any questions or concerns about this Privacy Policy, please contact us:

Address: 1700 Westlake Ave N, Ste 100, Seattle, WA 98109

Phone: 206-257-3350

Email: support@soundhandortho.com

9. Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

I have read, and accept the privacy policy terms outlined above. With this signature below I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing.

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