Orlando Matias, D.O., P.C.
2104 Jolly Rd., Ste. 290
Okemos, MI 48864
Phone (517) 220-4507
Fax (517) 575-6869

Name: _____
Legal First Name (preferred name) Middle Last

Date of Birth: _____ Sex (please circle): Male Female Other

Address: _____, MI _____
Street City Zip Code

Home Phone: _____ Cell Phone*: _____ Work Phone: _____
*Please indicate if Home number and Cell number are the same

Which phone number would you like us to use as your preferred number? HOME CELL WORK

Would you like to receive your appointment reminders via text message*? YES NO

Social Security Number: _____ E-Mail Address: _____
By providing your email, we will sign you up to view your patient portal on our website. You can view select medical records, send secured messages to the office, verify your upcoming appointments and more! A username and password will be emailed to you.

Primary Insurance: _____ Secondary Insurance (if applicable): _____

Name of Preferred Pharmacy: _____ Location: _____
Street Name/Nearest Crossroads

If under 18, Parent/Guardian Name: _____ DOB: _____ Relationship: _____

Spouse's Name: _____ DOB: _____ Phone Number: _____

Emergency Contact Name: _____ Phone Number: _____

Address: _____ Relationship: _____

PLEASE CIRCLE ALL THAT APPLY:

Race: Asian Black/African American Hispanic/Latino White Native Hawaiian/Other Pacific Islander
American Indian or Alaska Native Other Race Decline to Report

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Decline to Report

Authorization to Access External Prescription Databases

I hereby authorize the named health care provider Orlando Matias, D.O. to access any and/or all external databases available to healthcare providers in the State of Michigan which reflect the prescription medications filled/ordered/or used by me on a frequency to be determined by the provider. I understand that this information will be used to verify current medications, coordinate care, and to prevent drug interactions. This information will become part of my permanent medical record at Orlando Matias, D.O., P.C.

Assignment of Insurance Benefits/Authorization to Release Information

I hereby authorize direct payment of surgical / medical benefits to Dr. Orlando Matias, D.O. for services rendered by him or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize Dr. Orlando Matias, D.O. to release any medical / incidental information that may be necessary for either medical care or in processing applications for financial benefit. This information will become part of my permanent medical record at Orlando Matias, D.O., P.C.

PATIENT NAME (please print): _____ DATE: _____

SIGNATURE: _____ PARENT/GUARDIAN (please print): _____

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HIPAA Consent for Verbal Communication

PATIENT NAME: _____

_____ I give permission to physician and/or staff to release my lab, x-ray results, or any information to the people listed below over the phone.

_____ I give permission to physician and/or staff to release my lab, x-ray results, or any information by leaving a message on my answering machine.

_____ I give permission to physician and/or staff to verify, change or cancel appointments by leaving a message on my answering machine.

I understand that this release will stay in effect until written consent is received altering its contents.

Patient Signature: _____ Date: _____

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

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IN REGARDS TO NO SHOW APPOINTMENTS AND FINANCIAL POLICY

The intent of this document is to inform you of Orlando Matias, D.O., P.C.'s Financial Policy. It is our objective that all of our patients receive the best possible care and service. Therefore, your complete understanding of our financial policy as it relates to your financial obligation is essential. Please read this document thoroughly.

***The office now offers telemedicine for certain encounters with Dr. Matias. These encounters are billed like an in-person office visit, where copays, co-insurance and deductibles are applied.

Due to insurance company policy, you are required to be seen by Dr. Matias at least once every three (3) years to remain an active patient of our practice.

** If you are a member of a health plan that Orlando Matias, D.O., P.C. participates with, we will submit your claim to your insurance company**. Your co-payment is expected on the day services are rendered**. Effective January 3, 2017, the billing service fee for any payment not received on the day of service is a **$25.00 additional charge** for each time your copay is not paid. This is an enforceable charge against your account that your insurance carrier does not cover which means those charges will be your responsibility. Patients will be billed in full for any services that their health plan deems as "not a benefit" or a "non-covered service."

** If the provider does not participate with your insurance carrier, payment in full will be your responsibility. Our billing department will send a bill to your insurance company as a courtesy to you.

** There is a charge of **.50 cents per page of medical records request**. Payment for these records will be collected prior to records being released. Copy time is 2-4 weeks depending on staff availability and amount of records requested. If applicable, a complimentary copy of your records will be sent to the physician of your choice.

** A **$35 fee** will be assessed for any check returned for non-sufficient funds.

** Medicare patients are responsible for their deductible, co-insurance and any services Medicare might deem as "Medically Unnecessary." Medicare patients may also be asked to sign an Advanced Beneficiary Notice (ABN) form as required by Medicare for some services.

** Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. All patients who do not show up for their scheduled appointments will be charged. This is an enforceable charge against your account that your insurance carrier does not cover which means those charges will be your responsibility.
There are no exceptions according to the insurance carriers. This includes all insurances.
To avoid these charges, you must keep your appointment and be on time or you need to **cancel at least twenty-four business hours prior** to your appointment.

**********NO SHOW/ NON-CANCELLED FEES**:

Regular office visit/Sick Call - $25.00	Pap - $50.00	Physicals - $50.00
Procedures - $50.00	Well child checks - $50.00	

Orlando Matias, D.O., P.C. reserves the right to turn any account over to collections if it is deemed that the account has been in default of payment or compliance with this policy. In the event you breach this agreement, you agree to pay all collection fees.

**I have read and understand the financial policy. I hereby agree to pay Orlando Matias, D.O., P.C. for any charges to my account due to a NO SHOW / NON-CANCELLED APPOINTMENT.

Patient/Responsible Party Signature | Relationship to Patient | Date

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Parental Consent for Medical Treatment

Child's information:

Childs Name | Date of Birth

Home Address | City | State | Zip

Parental Contact | Contact number

Caregiver information: (designated adult over the age of 18 authorized to bring minor child to appointments in my absence)

Caregiver's name | Relation to Patient | Phone Number

The above named caregiver shall be authorized to consent to routine and/or emergency treatment for the above named child, which may be required during my absence.

[ ] I give my permission for my child to bring themselves to an appointment(s) in my absence. Established care plans may continue. Any new treatment plan must be approved by me. A summary of care must be given to my child at the visit.

[ ] I give my permission for a caregiver (an adult over the age of 18) listed above to bring minor child to an appointment(s), if I am unable to be present at the time of the appointment.

[ ] This consent will be in effect until ___ day _____ 20___, unless earlier revoked by me.

[ ] This consent for caregiver treatment has no expiration and will be revoked upon written notice only.

This consent serves as permission for treatment by Orlando Matias, D.O., P.C. I acknowledge that parental consent is not required in emergency situations. I agree to pay for all services provided to my child in my absence.

Parent/legal guardian (circle one) | Date

Witness | Date

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Dear Patient,

I am not taking new patients who have recently had an accident, workman's compensation episode or requesting time off work, work restrictions or wanting narcotic pain medication for an existing condition. I will ***not*** give you narcotic prescriptions (examples including but not limited to, Vicodin, Percocet, Oxycontin, etc) for your pain. I will not complete any forms for you concerning medical marijuana, and I will not prescribe any medical marijuana. If that is why you are here, then you will need to find a new doctor, and your brief stay here will not be charged to you or your insurance.

If you are an existing patient in this office; and we suspect a problem with drug use (illicit or prescription) we, as physicians, may request random urine or blood tests.

Patient signature_____ Date:_____

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PAIN CONTRACT
FOR LONG-TERM CONTROLLED SUBSTANCE THERAPY
AND CHRONIC PAIN

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of a relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interaction or poor condition of treatment.)

2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:_____ phone:_____

3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professional who provide your health care for the purpose of maintaining accountability.

5. You may not share, sell or otherwise permit others to have access to these medications.

6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.

7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presences of unauthorized substances may prompt referral for assessment for addictive disorder.

8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or have access to them.

9. Original containers of medications should be brought in to each office visit.

10. Since the drugs may be hazardous to lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

11. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.

12. Early refills will generally not be given.

13. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they be filled prior to the appropriate date.

14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality s waived and these authorities may be given full access to our records of controlled substance administration.

15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

16. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

17. It should be understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit.

18. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledged that you have received such explanation).

19. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

Physician signature	Patient signature
Date	Patient Name (Printed)

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NOTICE AND ACKNOWLEDGEMENT

Acknowledgment:

I acknowledge that I have received the attached Notice of Privacy Practices.

Patient Signature	Date
Personal Representative Signature and relationship to patient (If patient is a minor)	Date

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Authorization for Disclosure of Medical Record Information

Patient Name: _____ DOB: _____
Address: _____
_____ Phone: _____

I hereby authorize Orlando Matias, D.O., P.C., to

_____ Release information **to:**
Name or title of person or organization:
_____
Address: _____
Phone: _____ Fax: _____

_____ Release information **from:**
Name or title of person or organization:
_____
Address: _____
Phone: _____ Fax: _____

1. Extent or Nature of Information to be Disclosed:
   _____
   (Dates of treatment, diagnoses, progress notes, labs, x-rays, all records, etc.)
2. Purpose or Need for the Disclosure:
   _____
   (Follow up care, lawsuit, etc.)
3. I understand that as set forth in Orlando Matias, D.O., P.C.'s Notice of Privacy Practice, I have the right to revoke this authorization, in writing, any time by sending written notification.

Patient/Parent/Legal Guardian Signature: _____
Relationship: _____ Date: _____
Witness Signature: _____ Date: _____

In addition to the above patient inform, if my records contain diagnoses and or treatment for substance abuse (including alcoholism) and or mental health counseling, and or AIDS, ARC, or HIV testing, I authorize the release of that information under the above conditions. I understand that this specific authorization is needed because the Federal Regulations provide confidentiality of that information.

Patient/Parent/Legal Guardian Signature: _____
Relationship: _____ Date: _____
Witness Signature: _____ Date: _____
Reason Patient Cannot Sign: _____Minor _____Deceased _____Other: _____

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Patient Center Medical Home (PCMH): is a trusting partnership between a physician and an informed patient. It includes an agreement between the doctor and the patient to work together to provide the overall goal of wellness.

We will:
- Ask what your goal is, or what you want to do to improve your health
- Ask you to help us plan your care, and to let us know if you think you can follow the plan
- Be a resource if medical knowledge to provide you with information about your condition in understandable terms
- Provide you with compassionate care to treat your medical conditions and specific diagnosis
- Ask you to have blood tests done before your visit so that the doctor has your results at your visit
- Explore methods to care for you better, including ways to help you care for yourself

We trust you, our patient, to:
- Tell us what you know about your health and illnesses
- Tell us about your needs and concerns
- Take part in planning your care
- 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
- Tell us what medications you are taking and ask for a refill at your office visit when you need one
- Let us know when you see other doctors and what medications they put you on or change
- Ask other doctors to send us a report about your care when you see them
- Seek our advice before you see other physicians. We may be able to care for you and we know about the strengths of various specialists
- Learn about wellness and how to prevent disease
- Learn about your insurance so you know what it covers
- Respect us as individuals and partners in your care
- Keep your appointments as scheduled, or call and let us know when you cannot
- Pay your share of the visit fee when you are seen in the office
- Give us feedback so we can improve our services (we may survey you in the future to understand this better)
- **Test results:** Our office will notify you regarding abnormal tests within 2 business days of receiving them by phone or letter. In the event they are abnormal we may ask to schedule an appointment to discuss them with your physician
- If you have not heard from this office in one week and would like to know your results, please call us.

We will continue to:
- Provide you with a care team who will know you and your family and provide care management services
- Respect you as an individual
- Respect your privacy: your medical information will not be shared with anyone unless you give us permission or it is required by law
- Give the care you need when you need it
- Give care that meets your needs and fits with your goals and values
- Give care that is based on quality and safety
- Offer you access to a physician 24 hours a day and 7 days a week
- Take care of short illness, long term disease and give advice to help you stay healthy
- Explain your health and illnesses in a way you can understand
- Evaluate and incorporate healthcare technology in the practice of medicine
- Provide you with community resource information

SERVICES AVAILABLE

- Family medicine
- Pediatrics
- Pap smears
- Wart removals
- Mole removals
- Toe nail removal
- Sutures and Suture removal
- Diabetic patients
- Lab services on site

HOURS OF OPERATION:
8:00 - 5:00 PM MON - THURS
8:00 - 12:00 PM FRIDAY
Most insurances accepted

AFTER HOURS: 517-226-5772
Is the physician's pager number.

AFTER HOUR CLINICS:

Sparrow Urgent Care
517-333-6562
Hours: 8a - 8p, East Lansing

ORLANDO MATIAS, D.O., P.C.
HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: _____February 16, 2026___

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT THE HIPAA PRIVACY OFFER IDENTIFIED BELOW

Your medical information is personal. We are committed to protecting your medical information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office whether made by your personal physician or one of the office's employees.
This Notice will tell you about the ways in which we may use and disclose your medical information. This Notice will also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.
This office is required by law to:
(1) make sure that medical information that identifies you is kept private;
(2) give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
(3) follow the terms of the Notice that is currently in effect.

HOW THIS OFFICE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION:

The following describes the different ways that your medical information may be used or disclosed by this office. For clarification we have included some examples. Not every possible use or disclosure is specifically mentioned. However, all of the ways we are permitted to use and disclose your medical information will fit within one of these general categories:
For Treatment. We will use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians and other office personnel who are involved in providing you medical treatment.
For Payment. We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received here so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

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

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

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

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

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.

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

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

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

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

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

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

Uses and Disclosures Requiring an Authorization

Other uses and disclosures of your medical information not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us such an authorization in writing to use or disclose medical information about you, you may revoke that authorization, in writing, at any time, except to the extent that we have acted in reliance of it. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. The following are examples of uses and disclosures requiring an authorization:

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

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

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

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

[For Covered Entities that engage in fundraising activities only] If we create or maintain records subject to 42 CFR part 2 and wish to use or disclose such records for our fundraising purposes, we must first provide you with a clear and conspicuous opportunity to elect not to receive any fundraising communications.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

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

Right to Inspect and Copy. You have the right to inspect and copy your medical information with the exception of any psychotherapy notes.

To inspect and copy your medical information, you must submit your request in writing to HIPAA Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. For information regarding such a review contact the HIPAA Privacy Officer.

If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by this office.

To request an amendment, your request must be made in writing and submitted to the HIPAA Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

(a) Was not created by us;

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

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

(d) Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures this office has made of your medical information. We are not required to list certain disclosures, including disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations; however, if these disclosures were made through an electronic health record, you have the right to request, beginning on dates established by law or regulation, an accounting for such disclosures that were made during the previous 3 years.

To request this accounting of disclosures, you must submit your request in writing to the HIPAA Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure we make of your medical information.

We are not required to agree to your request for a restriction, except as noted below. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

We are required to agree to your request for a restriction if, except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment or health care operations (and is not for purposes of carrying out treatment) and the medical information pertains solely to a health care item or service for which we have been paid out of pocket in full.

To request restrictions, you must make your request in writing to the HIPAA Privacy Officer.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in a certain manner. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the HIPAA Privacy Officer. We will accommodate all reasonable requests.
Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.
You may obtain a copy of this Notice at our website at the address listed below.
To obtain a paper copy of this Notice, contact the HIPAA Privacy Officer.
Right to Receive Notice of Discovery of a Breach of Unsecured Protected Health Information. We are required to notify you of any breach of unsecured protected health information concerning you following the discovery of the breach when required by regulation.
REVISIONS TO THIS NOTICE:
We reserve the right to revise this Notice. Any revised Notice will be effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of any revised Notice in this office. Any revised Notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you visit the office we will offer you a copy of the current Notice in effect.

COMPLAINTS:

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

HIPAA Privacy Office: Georgeanne Matias (517) 220 - 4507

ORLANDO MATIAS, DO PC
2104 JOLLY ROAD, SUITE 290
OKEMOS, MICHIGAN 48864
Phone: 517-220-4507
Fax: 517-575-6869

Our website address is www.matiasdo.com.

All complaints must be submitted in writing.
THIS OFFICE WILL NOT PENALIZE YOU IN ANY WAY FOR FILING A COMPLAINT.