NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. OUR LEGAL DUTY

We are required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices, and follow the terms currently in effect.

2. HOW WE MAY USE AND DISCLOSE YOUR INFORMATION

We may use and disclose your PHI without your written authorization for the following purposes:

Treatment:
To provide, coordinate, or manage your healthcare and related services at New York Brain, Spine & Joint. This includes communication among providers in our multidisciplinary clinic (e.g., physicians, therapists, specialists).

Payment:
To bill and collect payment for services provided to you, including sharing information with insurance companies.

Healthcare Operations:
To operate our clinic, including quality assessment, staff training, licensing, and administrative functions.

3. OTHER PERMITTED USES AND DISCLOSURES

We may also use or disclose your PHI without your authorization when required or permitted by law, including:

- Public health activities (e.g., disease reporting)
- Health oversight activities (e.g., audits, inspections)
- Legal proceedings (court orders, subpoenas)
- Law enforcement purposes
- To avert a serious threat to health or safety
- Workers' compensation claims

4. USES REQUIRING YOUR AUTHORIZATION

We will obtain your written authorization before:

- Using or disclosing psychotherapy notes (if applicable)
- Marketing communications (where required)
- Sale of your health information: We do not sell your health information. However, should we ever intend to do so, we are required by law to obtain your written authorization first.

You may revoke your authorization at any time in writing.

5. ADDITIONAL PROTECTIONS UNDER NEW YORK LAW

Certain types of information have extra protection under New York State and federal law, including:

- Mental health records

Effective Date: April 28, 2026

- HIV/AIDS-related information
- Substance use disorder treatment records
- Genetic testing information

We will not disclose this information without your specific written consent unless otherwise permitted by law.

6. YOUR RIGHTS

You have the following rights regarding your health information:

Right to Access: You may request copies of your medical records.

Right to Amend: You may request corrections to your records if you believe they are incorrect.

Right to an Accounting of Disclosures: You may request a list of certain disclosures we have made.

Right to Request Restrictions: You may request limits on how we use or disclose your information (we are not always required to agree).

Right to Confidential Communications: You may request we contact you in a specific way (e.g., only by mail).

Right to a Paper Copy: You may request a paper copy of this Notice at any time.

7. BREACH NOTIFICATION

You will be notified if a breach occurs that may have compromised the privacy or security of your information.

8. CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. Any changes will apply to all information we maintain and will be posted in our clinic and on our website (if applicable).

9. CONTACT INFORMATION

If you have questions, concerns, or wish to exercise your rights, please contact:

Privacy Officer: _____
Clinic Name: _____
Address: _____
Phone: _____
Email: _____

10. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with New York Brain, Spine & Joint or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

APPOINTMENT, NO-SHOW & SURGERY CANCELLATION POLICY

At New York Brain, Spine & Joint/Link Medical Services PLLC, appointments and surgical procedures require dedicated physician time, staff coordination, and reserved clinical resources. We respectfully ask patients to provide timely notice if plans change so that we may offer appointments to others in need of care.

Office Appointments

If you are unable to attend your appointment, please notify our office at least **24 hours in advance**.

Appointments cancelled with **less than 24 hours' notice** may be subject to a $25 cancellation fee.

Patients who fail to attend an appointment without notice may be considered a No-Show and may be charged a **$25 No-Show fee**.

We understand emergencies and unforeseen circumstances occur. Cancellation fees may be reviewed on a case-by-case basis at the discretion of the practice.

Surgery Cancellation Policy

Because operating room time, staffing, and medical resources are reserved in advance, surgery cancellations may result in substantial costs to the practice.

Once a surgical date has been confirmed:

- A $1,500 surgery cancellation fee may apply for canceled procedures.
- A $3,000 surgery cancellation fee may apply if cancellation occurs within fourteen (14) days of the scheduled procedure date.

These fees are generally **not covered by insurance** and are the patient's financial responsibility.

Patient Acknowledgment

By signing below, I acknowledge that I have read and understand this Appointment, No-Show, and Surgery Cancellation Policy. I understand that failure to provide required notice may result in fees that are my financial responsibility and may be charged in accordance with my signed credit card authorization.

NOTICE TO PATIENTS: Because of concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has a financial interest, New York State passed a law. The law prohibits me, with certain exceptions, from referring you for clinical laboratory services, pharmacy services, radiation therapy services, or x-ray or imaging services to a facility in which I or any of my immediate family members have a financial interest. If certain exceptions in the law apply, or if I am referring you for other than clinical laboratory, pharmacy, radiation therapy, or x-ray or imaging services, I can make the referral under one condition. The condition is that I disclose this financial interest and tell you about alternative providers where you may go to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care.

I or my immediate family members have a financial relationship with the following providers:

NITIN MARIWALLA MD, PLLC

For more information about alternative providers, please ask me or my staff. We will provide you with names and addresses of providers best suited to your individual needs that are nearest to your home or place of work.

Sincerely

Dr Nitin Mariwalla