Coastal Spine & Pain

INTERVENTIONAL PAIN MANAGEMENT

150 W Peachtree Avenue • Foley, AL 36535 • Phone: (251) 291-2311 • Fax: 1-888-894-5212

NOTICE OF PRIVACY PRACTICES

Effective Date: May 1, 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.

OUR COMMITMENT TO YOUR PRIVACY

Coastal Spine & Pain, LLC ("we," "our," or "the Practice") is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and their implementing regulations (45 C.F.R. Parts 160 and 164), to maintain the privacy and security of your protected health information ("PHI"). We are also required to provide you with this Notice of our legal duties and privacy practices with respect to your PHI.

This Notice applies to all records of your care generated or maintained by this Practice, whether created by your physician, our staff, or other healthcare professionals working in our office. We are required to abide by the terms of this Notice currently in effect. We reserve the right to change the terms of this Notice at any time. Any revised Notice will be effective for all PHI we maintain at that time. A copy of the current Notice will be posted in our office and on our website at www.coastal-spine.com.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Uses and Disclosures That Do Not Require Your Authorization

Treatment. We may use and disclose your PHI to provide, coordinate, or manage your healthcare and related services. This includes consultations between healthcare providers regarding your care, referrals to other providers, and prescriptions. For example, we may share information about your condition with a surgeon to whom you are referred, or with an ambulatory surgery center where your procedure will be performed.

Payment. We may use and disclose your PHI to obtain payment for services we provide to you. This may include billing your insurance company, submitting claims, obtaining pre-authorization, and determining your eligibility for benefits. For example, we may send your diagnosis and procedure codes to your health plan so that your plan will reimburse us or pay you for the services rendered.

Healthcare Operations. We may use and disclose your PHI for our healthcare operations, which include quality assessment and improvement, reviewing the competence or qualifications of healthcare professionals, training programs, accreditation, certification, licensing, credentialing activities, business planning, and general administrative activities.

Appointment Reminders and Health-Related Communications. We may use your PHI to contact you to remind you of appointments or to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law. We may use or disclose your PHI when required to do so by federal, state, or local law. This includes reporting certain diseases, injuries, and events to public health authorities; reporting suspected abuse, neglect, or domestic violence; and responding to lawful court orders, subpoenas, or other legal process.

Public Health and Safety. We may disclose your PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety; to authorized federal officials for intelligence, counterintelligence, or national security activities; and to correctional institutions regarding inmates, as permitted by law.

Workers' Compensation. We may disclose your PHI as authorized by and to the extent necessary to comply with workers' compensation laws or similar programs.

Health Oversight Activities. We may disclose PHI to health oversight agencies for activities authorized by law, including audits, investigations, inspections, and licensure.

Uses and Disclosures That Require Your Written Authorization

We will obtain your written authorization before using or disclosing your PHI for purposes other than those described above (or as otherwise permitted or required by law). Specifically, we will obtain your authorization before:

- Using or disclosing psychotherapy notes (if applicable)
- Using your PHI for marketing purposes
- Selling your PHI
- Making most other uses and disclosures not described in this Notice

You may revoke any authorization at any time by submitting a written request to our Privacy Officer. Revocation will not affect any actions we took in reliance on the authorization before we received your revocation.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy. You have the right to inspect and obtain a copy of your PHI contained in a designated record set for as long as we maintain it. Your request must be in writing. We may charge a reasonable, cost-based fee for copies. We may deny your request in certain limited circumstances; if we do, you may request a review of the denial.

Right to Amend. You have the right to request that we amend your PHI if you believe it is incorrect or incomplete. Your request must be in writing and must provide a reason for the amendment. We may deny your request under certain circumstances, such as if we determine the information is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures of your PHI made by us during the six (6) years prior to the date of your request. This accounting will not include disclosures made for treatment, payment, or healthcare operations; disclosures made to you or authorized by you; or certain other disclosures.

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your PHI. We are not required to agree to your request except where the disclosure is to a health plan for payment or healthcare operations purposes, and you have paid for the service in full out of pocket.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. For example, you may ask that we contact you only by mail or at work. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice upon request, even if you previously agreed to receive the Notice electronically.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured PHI, as defined under HIPAA and HITECH.

QUESTIONS, CONCERNS, AND COMPLAINTS

If you have questions about this Notice or wish to exercise any of your rights, please contact our Privacy Officer:

Privacy Officer: Richard Webb, M.D., J.D., LL.M.
Coastal Spine & Pain, LLC
150 W Peachtree Avenue, Foley, AL 36535
Phone: (251) 291-2311 • Fax: 1-888-894-5212

If you believe your privacy rights have been violated, you may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. You will not be penalized or retaliated against for filing a complaint.

U.S. Department of Health and Human Services — Office for Civil Rights
Sam Nunn Atlanta Federal Center, 61 Forsyth Street SW, Suite 3B70, Atlanta, GA 30303
Phone: (404) 562-7886 • Online: www.hhs.gov/ocr/privacy

Coastal Spine & Pain

I N T E R V E N T I O N A L P A I N M A N A G E M E N T

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Coastal Spine & Pain, LLC Notice of Privacy Practices, which describes how my protected health information (PHI) may be used and disclosed by the Practice. I understand that I may request a copy of this Notice at any time.

I understand that Coastal Spine & Pain, LLC reserves the right to change its privacy practices and that I may obtain a revised Notice by requesting one at the front desk or by visiting www.coastal-spine.com.

I understand that I have the right to request restrictions on certain uses and disclosures of my PHI as described in the Notice. I understand that the Practice is not required to agree to my requested restrictions, except as required under HIPAA/HITECH.

I understand that I may revoke any authorization I give regarding the use and disclosure of my PHI, except to the extent that the Practice has already taken action in reliance upon my authorization.

Patient Name (Printed)		*Date*

Patient Signature (or Legal Representative)		*Relationship to Patient (if applicable)*

FOR OFFICE USE ONLY — If Unable to Obtain Acknowledgment

We attempted to obtain the patient's written acknowledgment of receipt of our Notice of Privacy Practices, but were unable to do so for the following reason:

☐ Patient refused to sign

☐ Emergency treatment situation

☐ Communication barrier

☐ Other: _____

Staff Signature: _____ Date: _____