ELITE HEARING & BALANCE

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NOTICE OF PRIVACY PRACTICES

Effective Date: August 12, 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 Legal Duty

We are required by federal and state law to maintain the privacy of your protected health information, also called "PHI". We are required to provide you with this Notice of Privacy Practices, which explains our legal duties and privacy practices regarding your health information. We are required to follow the terms of this Notice while it is in effect. We are also required to notify affected individuals following a breach of unsecured protected health information, as required by law.

This Notice is effective August 12, 2026, and will remain in effect until we replace it.

We reserve the right to change this Notice and our privacy practices at any time, as permitted by law. Any revised Notice may apply to PHI we already maintain, as well as PHI we create or receive in the future. When we make a material change, we will post the revised Notice in our clinic and on our website, if applicable. Copies of the current Notice will be available upon request.

What Protected Health Information Means

Protected health information includes information that identifies you and relates to your past, present, or future health condition, health care services, or payment for health care services. For an audiology clinic, PHI may include hearing test results, audiograms, balance testing information, hearing aid evaluations, hearing aid fitting and programming information, device warranty or repair information, physician referrals, treatment notes, insurance information, payment records, appointment history, and communications with you about your care.

How We May Use and Disclose Your Health Information

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

Treatment: We may use and disclose your PHI to provide, coordinate, or manage your care. For example, we may share your hearing test results, treatment recommendations, hearing aid information, or balance-related records with your primary care physician, referring provider, ENT physician, other health care providers involved in your care, or hearing aid manufacturers when needed for fitting, programming, warranty, repair, service, or patient support.

Payment: We may use and disclose your PHI to bill and collect payment for services, devices, supplies, or products we provide to you. For example, we may disclose information to your health insurance plan, Medicare, Medicaid, a third-party payer, a financing company, or another billing-related entity to determine eligibility, obtain prior authorization, submit claims, coordinate benefits, or collect payment.

Health Care Operations: We may use and disclose your PHI for our health care operations. These activities may include quality assessment and improvement, staff training, care coordination, licensure, credentialing, certification, compliance, auditing, business planning, patient satisfaction, and other activities necessary to operate our clinic.

Appointment Reminders and Care Communications: We may contact you by phone, text message, email, voicemail, mail, or patient portal to remind you about appointments, follow up about care, discuss hearing devices, provide test-related information, or communicate about services. You may ask us to contact you in a specific way as described below.

Health-Related Services and Treatment Alternatives: We may contact you about treatment options, hearing-related services, device updates, repairs, warranties, hearing protection, assistive listening devices, or other health-related benefits or services that may be of interest to you, as permitted by law.

Other Permitted Uses and Disclosures Without Your Authorization

We may use or disclose your PHI without your written authorization in the following situations, when permitted or required by law.

Required by Law: We may use or disclose your health information when federal, state, or local law requires us to do so.

Public Health and Safety: We may disclose your health information for public health or safety purposes, such as reporting disease, injury, abuse, neglect, domestic violence, device problems, product recalls, or serious threats to health or safety, when permitted or required by law.

Health Oversight Activities: We may disclose your PHI to health oversight agencies for activities authorized by law, such as audits, investigations, inspections, licensing, credentialing, disciplinary actions, or compliance reviews.

Judicial, Administrative, and Law Enforcement Matters: We may disclose your health information in response to a court order, administrative order, subpoena, discovery request, other lawful process, or to law enforcement officials when permitted or required by law.

Workers' Compensation: We may disclose your health information as authorized by, and to the extent necessary to comply with, workers' compensation laws or similar programs, including when your audiology care is related to a workplace injury, occupational hearing condition, or workers' compensation claim.

Business Associates and Vendors: We may disclose health information to business associates and vendors who perform services for us, such as billing, technology support, electronic health records, device support, accounting, legal, consulting, or administrative services. These vendors are required to protect your health information as required by law and their agreements with us.

U.S. Department of Health and Human Services: We may disclose your health information to the U.S. Department of Health and Human Services when required to investigate or determine our compliance with HIPAA.

Other Special Situations: We may disclose health information for other purposes permitted or required by law, such as disaster relief, coroner or medical examiner requests, certain government functions, or other legally authorized purposes. Some types of health information may receive additional protection under federal or Arizona law. If stricter protections apply, we will follow the stricter law.

Uses and Disclosures That Require Your Written Authorization

We will obtain your written authorization, or the written authorization of a parent, legal guardian, or other authorized representative, as applicable, before using or disclosing your PHI for purposes other than those described above, including uses and disclosures of PHI for marketing purposes and disclosures that would constitute a sale of PHI. Elite Hearing & Balance will not sell your PHI. You may revoke this authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

You have the right to:

Inspect and Obtain a Copy of Your Records. You have the right to inspect and obtain a copy of your medical records and payment records, subject to limited exceptions under HIPAA and Arizona law. Requests must be made in writing and signed by you, your legal guardian, or your health care decision maker, as applicable. You may request an electronic copy of your health information. If we cannot readily provide the requested electronic format, we will provide it in another readable format as permitted by law. We may charge a reasonable, cost-based fee for copying, mailing, or other permitted supplies associated with your request.

Request an amendment of PHI. If you believe PHI we maintain about you is incorrect or incomplete, you may ask us to amend it. Requests must be made in writing and explain why an amendment is needed. We may deny your request in certain circumstances. If denied, we will provide a written explanation and describe your rights.

Receive an accounting of disclosures of PHI. You have the right to request a list of certain disclosures of your PHI from the past six years. This list does not include disclosures made for treatment, payment, health care operations, to you, with your authorization, to family or others involved in your care or payment where permitted by law, or other disclosures excluded by law. Requests must be made in writing. We may charge a reasonable, cost-based fee for more than one request in a 12-month period.

Request a restriction on certain uses and disclosures of PHI. You may request limits on how we use or disclose your PHI for treatment, payment, or health care operations, including disclosures to family members, friends, caregivers, or others involved in your care or payment. Requests must be made in writing. We are not required to agree, except when you pay in full out-of-pocket and ask us not to disclose that information to your health plan, unless disclosure is required by law.

Request confidential communications. You may ask us to contact you in a specific way or at a specific location, such as by a certain phone number, address, email, or other reasonable method. Requests must be made in writing. We will accommodate reasonable requests.

Obtain a paper copy of the Notice upon request. You may request a copy of our current Notice at any time by emailing care@elitehearingbalance.com, even if you agreed to receive the Notice electronically.

Receive notice of a breach. You have the right to receive notice if there is a breach of your unsecured PHI, as required by law.

Report a Problem

If you believe your privacy rights have been violated, you may file a complaint with **Elite Hearing & Balance** by contacting us at **care@elitehearingbalance.com** or by mail at 1757 E Baseline Rd Ste 111, Gilbert, AZ 85233. You may also file a complaint with 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.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided with a copy of Elite Hearing & Balance's Notice of Privacy Practices, which explains how my protected health information may be used and disclosed and describes my rights regarding my protected health information.

_____ _____

Patient Name Date

_____ _____

Patient or Authorized Representative Signature Relationship to patient, if signed by representative

FOR CLINIC STAFF USE ONLY

If acknowledgment could not be obtained, check the reason below and sign:

☐ Patient refused ☐ Emergency ☐ Communication barrier ☐ Other:_____

_____ _____

Staff Signature Date