Valor Medical Intake Form

Patient Name (First, Mid, Last): ____ **Maiden Name**: ___________________
Date of Birth: ______________________ **Sex**: Male ____ Female ____ Other: ___________________________________
SSN (required): ______ - ______ - __________ **Marital Status**: Single ____ Married ____ Divorced ____ Widowed ____
Address: ____
City: ____ **State**: ________________ **Zip Code**: __________________
Email: ____ **Occupation**: ____
Main Phone: ____________________________________ **Alternate Phone**: ______________________________________
Emergency Contact: ___________________________________ **Relationship**: _____________________________________
Emergency Contact Phone: ____
Patient Referred By: ____
Pharmacy Name (most frequently used): ____
Address: ____
City: ____ **State**: ______________ **Zip Code**: _________________
Phone: ____ **Fax**: ____

Other Patient Information

Which racial category does the patient most closely identify with?

____ African American ____ Asian ____ Caucasian ____ Hispanic or Latino

____ Native American ____ Native Hawaiian ____ Pacific Islander ____ Not Hispanic or Latino

____ Other: ________________________________

What is the patient's language of choice? ____ English ____ Spanish ____ Other: ________________

Insurance Information

Primary Insurance: ____
Policy/ ID: ____ **Group/ Acct**: ______________________________________
Policy Holder Name: ____ **Date of Birth**: ___________________
Employer: ____
Employer Address: ____
City: ____ **State**: ______________ **Zip Code**: __________________

Secondary Insurance: ____
Policy/ ID: ____ **Group/ Acct**: ______________________________________
Policy Holder Name: ____ **Date of Birth**: ___________________
Employer: ____
Employer Address: ____
City: ____ **State**: ______________ **Zip Code**: __________________

Complete Only if Patient Is a Minor

Parent/Guardian Name: ____ **Relationship**: ___________________
Parent/Guardian Contact Phone: ____
Parent/Guardian Name: ____ **Relationship**: ___________________
Parent/Guardian Contact Phone: ____

Valor Medical Contact and Notices Form

Patient Name: ____ **Date of Birth**: ____________________

Assignment of Benefits: I authorize Valor Medical, or "VM" to submit claims on my behalf directly to Medicare/ Medicaid/ my private health insurance carrier. This means that VM will collect payment for supplies and services provided. I understand that I am financially responsible to the Provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient Initials: ________

Consent for Treatment: I consent for VM to administer treatments, tests, and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF): or if a medical or surgical procedure could expose another individual to my/the patient's BBF. VM may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at VM's expense.

Patient Initials: ________

Electronic Prescription: I understand VM utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Patient Initials: ________

Phone Calls: By providing contact information, I authorize VM, its assignees, and third-party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/ cellular/ employment telephone: leave voicemail or text messages: and use pre-recorded/ artificial/ voice messages and/or auto-dialing in connection with any communication to me.

Patient Initials: ________

Name	Relationship	Phone	OK to discuss HIPAA PHI or ER Contact Only?

____ I DO NOT wish to add an additional contact(s) to discuss my/patient's needs. **Patient Initials:** ________

May We Contact You by Phone and Leave a Message About Your Care?

Main Phone # ________________________________

___ Leave a message with contact number only.
___ Leave a message with detailed information.
___ Do not leave a message.

Alt Phone # ________________________________

___ Leave a message with contact number only.
___ Leave a message with detailed information.
___ Do not leave a message.

Valor Medical Contact and Notices Form

Patient Name: ______________________________ **Date of Birth**: ____________________

Patient Financial Responsibility Notice **Patient Initials:** ________
I acknowledge receipt of the "Patient Financial Responsibility Notice"

Notice of No-Show Policy **Patient Initials:** ________

Chronic Care Management Patient Agreement **Patient Initials:** ________

HIPAA Notice of Privacy Practices **Patient Initials:** ________
I acknowledge that I have been offered a copy of VM's privacy practices.

Patients' Rights and Responsibilities **Patient Initials:** ________
I acknowledge that I have been offered a copy of VM's patient rights and responsibilities.

Minor Patient Photograph (when applicable) **Patient Initials:** ________
I consent for VM to photograph the minor patient for identification purposes only.

____
Print Name of Patient or Parent/Guardian

____ ____________________
Signature of Patient or Parent/Guardian Date

Valor Medical History Form

Patient Name: ____ **Date of Birth**: ________________

Allergies (Include medications, foods, X-Ray dyes) **or** ____ No Known Allergies

Name of Allergy	Type of Reaction	Approximate Age of Onset

Current Medications (Include prescription, over the counter, and supplements) **or** ____ No Current Medications

Name of Medication	Reason for Medication	Dosage / Frequency	Approx. Date Started

OB/GYN History: ___ N/A (Male) **or** Last Pap Smear: _____________________ Results: Normal Abnormal
Last Menstrual Cycle: ______________ Pregnancies (#): ______ Live Births (#): ______

Tobacco History

Are you an active cigarette smoker? ____ Yes ____ No
Have you ever been a cigarette smoker? ____ Yes ____ No
If yes, I smoked an average of ______ packs per day for ______ years. ____ I quit in _________ (year)
Do you use other tobacco products? ____ Yes ____ No
If yes, please specify: ____

Alcohol and Drug History

Do you currently drink alcohol? ____ Yes ____ No
If yes, approximately how many drinks per week (beer, wine, or liquor): ______________________
Have you ever been diagnosed with alcoholism? ____ Yes ____ No
Do you use any illicit or recreational drugs? ____ Yes ____ No
If yes, what and approximately how often: ______________________________

Family History

Is there a history of:	**Yes**	**No**	**Type**	**Affected Relative(s)** (specify Maternal / Paternal)
Anxiety / Depression				
Asthma				
Cancer				
Emphysema / COPD				
Diabetes				
Heart Disease				
High Cholesterol				
High Blood Pressure				
Kidney Disease				
Stroke				
Substance Abuse / Addiction				
Thyroid Disease				
Other Significant Disease				

Valor Medical History Form

Patient Name: ______________________________ **Date of Birth**: ____________________

Surgical History: ___ N/A

Type of Surgery (specify Left / Right)	**Date Surgery Performed**	**Location / Facility**

GAD-7 Anxiety Screening

Over the last two weeks, how often have you been bothered by the following problems?	**Not at All**	**Several Days**	**More than half of the days**	**Nearly Every Day**
Feeling nervous, anxious, or "on edge"	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble Relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid, as if something awful might happen	0	1	2	3
Column Totals				

Total Score: __________________

If you marked any problems - How difficult have they made it for you to do your work, take care of things at home, or get along with other people? Not Difficult at All _____ Somewhat Difficult _____ Very Difficult _____ Extremely Difficult _____

PHQ-9 Screening

Over the last two weeks, how often have you been bothered by the following problems?	**Not at All**	**Several Days**	**More than half of the days**	**Nearly Every Day**
Little interest or pleasure doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or having let yourself or others down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
Moving or speaking so slowly that other people have noticed the difference, or the opposite – being so fidgety or restless that you move around more than usual	0	1	2	3
Thoughts that you would be better off dead or of causing yourself harm in some way	0	1	2	3
Column Totals				

Total Score: __________________

If you marked any problems - How difficult have they made it for you to do your work, take care of things at home, or get along with other people? Not Difficult at All _____ Somewhat Difficult _____ Very Difficult _____ Extremely Difficult _____

Valor Medical History Form

Patient Name: ____ **Date of Birth**: __________________

Please check the complaint{s}, or ailment(s) that apply to you. If you are unsure, place a question mark (?)

General

- Fever __ Yes
- Night Sweats __ Yes
- Weight Gain __ Yes
- Weight Loss __ Yes
- Exercise Intolerance __ Yes
- Chills __ Yes
- Fatigue / Malaise __ Yes

Eyes

- Glasses/Contacts __ Yes
- Dry Eyes __ Yes
- Vision Changes __ Yes
- Irritation __ Yes
- Eye Disease / Injury __ Yes

Ears Nose Mouth Throat

- Difficulty Hearing __ Yes
- Ear Pain __ Yes
- Frequent Nosebleeds __ Yes
- Nose Problems __ Yes
- Sinus Problems __ Yes
- Sore Throat __ Yes
- Bleeding Gums __ Yes
- Snoring __ Yes
- Dry Mouth __ Yes
- Mouth Ulcers __ Yes
- Oral Abnormalities __ Yes
- Teeth Problems __ Yes
- Ringing in Ears __ Yes
- Sinusitis __ Yes

Cardiac (Heart)

- Chest Pain __ Yes
- Arm Pain on Exertion __ Yes
- Shortness of Breath (walking) __ Yes
- Shortness of Breath (laying) __ Yes
- Palpitations __ Yes
- Heart Murmur __ Yes
- Ankle/Foot Swelling __ Yes

Respiratory

- Cough __ Yes
- Wheezing __ Yes
- Shortness of Breath __ Yes
- Coughing Up Blood __ Yes
- Sleep Apnea __ Yes
- Use of Inhalers __ Yes

Gastro-Intestinal

- Abdominal Pain __ Yes
- Nausea __ Yes
- Vomiting __ Yes
- Constipation __ Yes
- Change of Appetite __ Yes
- Diarrhea __ Yes
- Black or Tarry Stools __ Yes
- Vomiting Blood __ Yes
- Dyspepsia __ Yes
- GERD __ Yes

Genito-Urinary

- Incontinence __ Yes
- Difficulty Urinating __ Yes
- Blood in Urine __ Yes
- Increased Frequency __ Yes
- Incomplete Emptying __ Yes

Males

- Blood in Urine __ Yes
- Erectile Dysfunction __ Yes
- Foul Odor of Urine __ Yes
- Pain in Testicles __ Yes
- Trouble Urinating __ Yes

Females

- Breast Discomfort __ Yes
- Irregular Bleeding __ Yes
- Painful Intercourse __ Yes
- Post-Menopausal Bleeding __ Yes
- Trouble Urinating __ Yes
- Vaginal Discharge __ Yes

Musculo Skeletal

- Muscle Aches __ Yes
- Muscle Weakness __ Yes
- Arthritis / Joint Pain __ Yes
- Back Pain __ Yes
- Extremity Swelling __ Yes
- Neck Pain __ Yes
- Difficulty Walking __ Yes
- Cramps __ Yes
- Osteoporosis __ Yes
- Fractures __ Yes

Skin Hair Nails

- Abnormal Mole __ Yes
- Jaundice __ Yes
- Rash __ Yes
- Itching __ Yes
- Skin Changes __ Yes
- Growths / Lesions __ Yes
- Lacerations __ Yes
- Non-Healing Areas __ Yes
- Changes in Hair/ Nails __ Yes
- Psoriasis __ Yes
- Changes in Skin Color __ Yes
- Breast Lump __ Yes

Neuro

- Loss of Consciousness __ Yes
- Weakness __ Yes
- Numbness __ Yes
- Seizures __ Yes
- Dizziness __ Yes
- Migraines __ Yes
- Tremor __ Yes
- Gait Dysfunction __ Yes
- Paralysis __ Yes

Mental Health		
	Depression	__ Yes
	Sleep Disturbances	__ Yes
	Restless Sleep	__ Yes
	Feeling Unsafe	__ Yes
	Alcohol Abuse	__ Yes
	Anxiety	__ Yes
	Hallucinations	__ Yes
	Suicidal Thoughts	__ Yes
	Mood Swings	__ Yes
	Memory Loss	__ Yes
	Agitation	__ Yes
	Dementia	__ Yes
	Delirium	__ Yes
	History of Physical / Mental Abuse	__ Yes

Endocrine		
	Fatigue	__ Yes
	Increased Thirst	__ Yes
	Hair Loss	__ Yes
	Hair Growth	__ Yes
	Cold Intolerance	__ Yes
	Heat Intolerance	__ Yes

Hemato-logic / Lymphatic		
	Swollen Glands	__ Yes
	Easy Bruising	__ Yes
	Excessive Bleeding	__ Yes
	Anemia	__ Yes
	Phlebitis	__ Yes

Allergic / Immuno-logic		
	Runny Nose	__ Yes
	Sinus Pressure	__ Yes
	Itching	__ Yes
	Hives	__ Yes
	Frequent Sneezing	__ Yes

Recent Tests: Give month/year of last exam in the right column. **Health Maintenance:** Check the left column if the date is estimated.

___ Bone Density: ____
___ Colonoscopy: ____
___ Diabetic Foot Exam: __________________________________
___ Eye Exam: ____
___ Mammogram: ____
___ Pap Smear: ____
___ Physical: ____
___ PSA: ____
___ Tetanus Shot: ____

Patient Name: ____ **Date of Birth**: ____________________

Valor Medical Record Release Form

I, ______________________________, do hereby authorize Valor Medical to obtain copies of my medical records.

Patient Name: ______________________________

Date of Birth: ____________________ **SSN:** ____________________

Address: ______________________________

City, State, Zip Code: ______________________________

Phone: ______________________________

I authorize the release of my/my child's medical records or other healthcare information including forms, chart notes, reports, consult notes, imaging/imaging reports, diagnostic testing, labs, correspondence, medications, personal histories, and other pertinent information concerning my health and treatment from:

Physician/Practice Name: ______________________________

Address: ______________________________

City, State, Zip Code: ______________________________

Phone: ____________________ **Fax:** ____________________

To be sent to:

Valor Medical
140 Market Place Blvd. Ste. E., Knoxville, TN 37922-2337
(P) 885-212-2211 **(F) 833-314-0589** info@valor-medical.com

___ Chart Notes ___ Medication List ___ Imaging / Other Diagnostics
___ Demographics ___ Consult Notes ___ Therapy Notes

___ Other: ______________________________

___ This authorization is good for one (1) year from the date signed, unless otherwise specified.

___ Other: ______________________________

Patient/Legal Guardian Signature: ______________________________

Relationship: ______________________________ **Date:** ____________________

Valor Medical   Credit Card Pre-Authorization Form

Patient Name: ______________________________________ **Date:** _________________ **Date of Birth**: _________________

Address: ____

City, State, Zip Code: ____

Email Address: ____

The Undersigned Patient / Cardholder hereby authorizes Valor Medical to obtain payment of fees for services from the Patient / Cardholder's Credit Card account identified on the patient's account. Valor Medical may charge the account for the missed appointments (minimum of 24 hours cancellation notice is required, as set forth in our missed appointments policy), without requirement of the Patient / Cardholder's signature for each payment. A Receipt of the transaction will be mailed to the physical address or email address provided by the Patient / Cardholder above.

By signing this form, the Patient / Cardholder acknowledges and agrees as follows:

- The signed form is confidential and will be kept on file at Valor Medical.
- The patient / Cardholder authorizes payments to be made on the above-named patient's account (including co-pays, co-insurances, deductibles, or missed appointment fees.)
- The Patient / Cardholder certifies, warrants, and represents that the Cardholder named below agrees to pay the credit charges(s) in accordance with the agreement described above.
- Credit Card payments will appear on your statement as Valor Medical.
- The Patient / Cardholder agrees that the charges are valid and agrees not to dispute said charges.
- This authorization will remain valid for 12 months and will automatically renew on an annual basis, unless revoked in writing with 30-day notice of revocation.
- This authorization serves as agreement for receipts to be noted, "signature on file" when charged.

____

Print Name of Authorized Signer

____   ________________________

Patient/Cardholder Authorized Signature   Date

Physical card to be given to reception to keep your data secure

Please Circle One: ___ Visa   ___ Mastercard   ___ Discover   ___ American Express

Name on Card: ____

Last 4 Digits ONLY of Credit Card Number: ____

Billing Address for Card: ____

____

Valor Medical Financial Responsibility Notice

Please Read Prior to Receiving Services

Valor Medical, or VM, recognizes the need for a clear understanding between patient and medical provider regarding financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning payment for professional services.

- **PAYMENT:**
  - **Copays -** Copays are expected at the time of service.
  - **Deductibles / Coinsurances -** If your deductible has not been met, or you have a percentage of coinsurance, it is your responsibility to assure payment of these amounts, as communicated to our office by your insurance company. Our office will file the insurance claim for your convenience, and you will then be responsible for any balance after insurance processes your claim. All charges for treatment become due and payable no later than sixty (60 days) after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25 charge for returned checks. If not paid within 60 days, VM will begin various collection activities including, but not limited to submitting the past due account to a collection agency.
  - **Self-Payment (Private, Cash Payment):** If you have no insurance coverage, we ask that you coordinate your care with our business office prior to your visit. We do offer payment plans on a case-by-case basis, but we do also require a payment at time of service for all professional services.

The following is not a comprehensive list and does not include any outside tests or medications.

Chronic Disease Management:
Base Price: $75 (not including diagnostic tests, treatments, or extra complexity)

Minor Illness/ Injury/ Acute Visits:
Base Price: $50 (not including diagnostic tests, treatments, or extra complexity)

Rapid Testing:
Rapid Flu Test: $30
Rapid Strep Test: $30
Rapid COVID-19 Antigen Test: $50
TB Testing (PPD Skin Test): Placement: $35, Reading: $25

Wellness and Physicals:
Adult Annual Exam Only: $50
Women's Annual Adult Physical with PAP (does not include diagnostic lab cost): $80
School / Sports Physical (Child): $35
Adult /College Physical: $50
DOT Physical: $90

**The above prices are only for the Annual Exams, if there are additional concerns that you'd like the Provider to address, then there would be an additional charge for the appropriate visit type)

Behavioral Health Counseling - $1/Min (New and Existing Patients)

MANAGED CARE: All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of services. If your insurance plan requires a specified Primary Care Physician (PCP), please present or ask for a "*Change of PCP*" form at your initial visit. If you request an office visit without changing Valor Medical to your PCP under these circumstances, your insurance plan may deem this as *"out of network" or "non-covered treatment"*, and you will be responsible for a larger amount, or all, of the charges. The patient acknowledges that it is their responsibility to be aware of what services are covered and agrees to pay for any service deemed to be *out of network or non-covered* by the plan.

- **MEDICARE:** Valor Medical Providers are participating Providers with the Medicare program and accept as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare and/or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, or Advanced Beneficiary Notice (ABN), which states that you understand that you will be responsible for these charges.
- **AUTOMOBILE ACCIDENT PATIENTS:** We do treat automobile accident patients. However, we are unable to monitor long-term accounts and require payment as a self-pay patient. We will not accept a letter of protection from an attorney as a guarantee of payment or third-party insurance program.
- **CHILDREN OF DIVORCED PARENTS:** Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgement must be determined between the individuals involved, without the inclusion of VM.
- **NO WORKERS COMPENSATION:** Valor Medical **does not** accept Workers Compensation Insurance.
- **NO SHOWS / MISSED APPOINTMENTS:** Failure to show for a scheduled appointment or notify our office of cancellations at least 24 hours prior to your appointment time, will result in a $50 missed appointment fee. This fee will be directly charged to a credit card that we will keep on file. We will send you a receipt notifying you immediately of the missed appointment charge. If you decline to provide a credit card upfront and incur a $50 missed appointment fee, we will mail you an invoice with a 10% surcharge resulting in a $55 fee. All remaining appointments will be cancelled, and you will not be rescheduled until the fee has been paid in full or payment arrangements have been made. After 3 missed visits/ late cancellations, you may be dismissed from the practice.
- **PATIENT PAYMENT PLANS:** We offer the opportunity to establish a reasonable payment plan if you are not able to pay in full at the time of service. If you have an outstanding balance, we expect you to make payment or payment arrangements before your next scheduled appointment. Non-payment may result in discharge from the practice.
- **NETWORK PARTICIPATION:** Before receiving services, you must verify that we are participating providers with your insurance company network. It may also be necessary that Valor Medical, or one of our Providers, is listed as your Primary Care Provider with your insurance company, if required by your contract with your insurance company. In the event we are *not* Participating Providers, or our Provider is not listed as your Primary Care Provider with your insurance company, we *will* file the initial claim as a courtesy. That said, the patient acknowledges that the services rendered may be covered at a lower percentage or not at all, and that any remaining balance is the responsibility of the patient.
- **PATIENT BALANCES:** We will send a statement to the email or billing address you provide notifying you of any balances you may owe. If you have questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call (865) 212-2211 and ask for the Billing Dept.
- **Failure to keep your account balance current may require us to cancel or to reschedule your appointments.**

Valor Medical firmly believes that a good patient/provider relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or not clarification regarding these policies, please call us at (865) 212-2211.

Valor Medical Chronic Care Management Patient Agreement

Medicare is offering a new benefit for beneficiaries with multiple chronic conditions, and by consenting to this agreement, you allow your provider to provide chronic care management services to you.

CCM Services are only available to patients with 2 or more chronic conditions. Medicare defines a chronic condition as a condition that is expected to last more than 12 months, and that increases the risk of death, acute exacerbation of disease, or decline in function.

Benefits of CCM Services Include:

- 24/7 access to a care provider to help with your chronic health needs
- A comprehensive plan of care for health needs, available on paper or electronically
- Coordination with both home and community-based service providers
- Transition management among health providers, including referrals, and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities
- Medication oversight and management
- Use of certified electronic health records as mandated by Medicare.

Beneficiary Acknowledgement and Agreement

By signing this agreement, you agree to the following terms:

- You consent to your provider furnishing CCM services to you
- You certify that your provider has fully explained the scope of CCM services to you
- You acknowledge that only one practitioner can furnish and be made primary provider for CCM services during a calendar month.
- You authorize electronic communication between treating providers as part of your care.
- You understand that CCM services are subject to Medicare Co-Insurance, and that you may be billed for a portion of the CCM services
- You understand that you have the right to terminate CCM services at any time by revoking this agreement effective at the end of the then-current month.
- You may revoke this agreement by notifying us via phone, or by mailing your written revocation to 140 Market Place Blvd Ste E, Knoxville, TN 37922. Your provider will then give you written confirmation, including the date of revocation for the CCM services.

HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates, and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your provider, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the provider's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your provider or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your provider is not required to agree to your requested restriction except if you request that the provider not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form.

Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

<u>Patients' Rights and Responsibilities</u>

Patients' Rights:

- Patients have the right to considerate, respectful care from their doctors, health plan representatives, and other health care providers that does not discriminate against them based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, or genetic information.
- Patients have the right to have their privacy protected.
- Patients have the right to receive confidential treatment of all communications and records pertaining to their care.
- Patients have the right to receive accurate and easy to understand information about their health plan, health care professionals, and health facilities.
- Patients have the right to choose health care providers who can give them high quality health care when they need it.
- Patients have the right to make suggestions to their insurance company about their insurance company's patients' rights and responsibilities.
- Patients have the right to work with their doctors in making decisions about their healthcare.
- Patients have the right to file complaints and appeals about their insurance company or the care it provides.
- Patients have the right to get the facts and discuss necessary treatment options for their condition, regardless of cost or insurance coverage.

Patients Responsibilities:

- Patients are responsible for following plans and instructions for care that has been agreed upon by their physician.
- Patient is responsible for supplying information that the insurance company, physicians, and hospital need to provide care.
- Patients are responsible for understanding their health problems and working with their physicians to come up with mutually agreed upon goals.
- Patients are responsible for notifying their physician if there is any change in their address, phone number, or insurance carrier.
- Patients are responsible for notifying their physician if they are unable to keep their appointment.
- Patients are responsible for calling their insurance company if they have any questions or problems.
- Patients are responsible for arriving on time for appointments.