Direct Primary Care Membership Contract

This Agreement is made between , Salameh Family Care, Inc., a Florida professional medical corporation, doing business as Salameh Family Care ("the Practice"), and you ("you" or "Patient"). The Practice offers primary care services in exchange for certain fees paid by you on the terms and conditions described below.

PATIENT AGREEMENT

1. Services. As used in this Agreement, the term Services means primary care services and certain amenities (collectively "Services") that are offered by the Practice.

a. Included Services.

i. Your membership includes well and sick care, basic preventative services, wellness exams and care as determined by the scope of primary care services. Your physician will make an appropriate determination about the scope of primary care services offered by the Practice on a case-by-case basis.

ii. The number of in-person and virtual visits you may receive is limited by this Agreement.

iii. Some Services available in our office, such as sports/ school physicals are available at no additional cost to you.

iv. Some Services, such as durable medical equipment, some vaccinations, and prescription medications, are available in our office and incur an additional fee.

v. The Practice reserves the right to modify the scope of Services offered at any time based on the professional judgment of the Practice's Physicians.

b. Excluded Services. You may need the care of emergency rooms, laboratory testing, pathology studies, prescribed medications, radiologic imaging, specialist consultations or treatment, surgery, urgent care centers, or other healthcare services that are outside the scope of this Agreement. We highly recommend that you maintain health insurance, which may or may not cover the costs of these services. The Practice will attempt to endeavor to place orders for Excluded Services in a manner that is cost effective for you.

2. Consent to Treat. You acknowledge, consent, and hereby authorize the Practice to carry out your healthcare treatment. Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the administration and use of prescribed medications, the performance of such procedures as may be deemed necessary or advisable for treatment, including but not limited to diagnostic procedures, the taking and utilization of cultures, and of other medically-accepted laboratory tests, all of which in the judgment of the attending Physician or their assigned designees may be considered medically necessary or advisable.

You acknowledge and understand that this consent is given in advance of any specific diagnosis or treatment, that these services are voluntary, and that you have the right to refuse these services. You understand and intend this consent to be continuing in nature, even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving your revocation.

3. Scheduling.

a. Availability. The Practice will make every effort to address your medical needs in a timely manner, but we cannot guarantee availability, and we cannot guarantee that you will not need to seek treatment in an urgent care or emergency department setting.

b. Missed Appointments. If you need to cancel a scheduled appointment, the cancellation must be completed at least 12 hours prior to your appointment. If you do not arrive for an appointment, or are significantly late, you may be charged a $25.00 fee. Exceptions to this policy may be granted at the Practice's discretion.

4. Fees. In exchange for Services, you agree to pay the Practice a) the Monthly Fee; b) the Enrollment Fee; and c) any additional Itemized Charges (collectively, the "Fees"). In order to remain financially viable, the Practice must, and does, reserve the right to change its fees at any time with 30 days' notice to you.

a. Monthly Fee. Your Monthly Fee is identified in the chart attached to this Agreement. Your Monthly Fee is billed in arrears. Your monthly fee is payable by automatic debit from your bank or credit card account.

b. Enrollment Fee. Your Enrollment Fee is **$100 for individuals or $200 for family memberships**. The Enrollment Fee covers the initial administrative cost of your membership and is not related to the provision of Services. This fee is payable upon execution of this Agreement and is no longer refundable either five (5) business days after you sign it, or as soon as you receive Services, whichever occurs first.

c. Itemized Charges. The fees for Itemized Charges change in response to our costs and we endeavor to make these services as affordable as possible. You will be made aware of the fees for Itemized Charges in advance of the services being performed. Payment for Itemized Charges is due at the time services are rendered.

5. Disclaimer of Non-Insurance. Fees paid are not health insurance. You acknowledge and understand that this Agreement is not a health insurance plan, and not a substitute for health insurance or other health plan coverage, and it does not meet any individual health plan mandates. Because this Agreement is not a health insurance plan, it is not subject to health insurance protections provided for by state law. This Agreement is solely for primary care services provided directly to you by the Practice. This Agreement does not cover hospital, specialist, or any services not directly provided by the Practice. It is highly recommended that you maintain health insurance for care you may need that is not part of our Services.

6. Non-Participation in Health Insurance. You acknowledge that neither the Practice, nor its Physicians participate in **any** public or private health insurance plans, including Medicare and Medicaid. Neither the Practice nor its Physicians make any representations regarding third party insurance reimbursement of Fees paid under this Agreement, and such reimbursement is not anticipated by this Agreement.

If your health plan is a managed care product like an HMO or an EPO, including Medicare Advantage Plans and our local managed care plan, the plan generally will not cover ancillary services such as labs, imaging, and specialist referrals that the Practice orders. While we are happy to work with you, you understand that these plans often require re-evaluation and further workup through your assigned primary care physician in those plans.

7. Non-Participation in Medicare. You specifically acknowledge that pursuant to federal regulations, the Practice and its Physicians have elected the "opt out" status of Medicare participation. This means that Medicare cannot be billed for any Services performed under this Agreement. Further, you agree not to bill Medicare or attempt Medicare reimbursement for any such Services. If you are eligible for Medicare, or during the term of this Agreement you become eligible for Medicare, then the Practice is required to obtain your understanding, memorialized by your signature, of our *Private Contract & Voluntary Advance Beneficiary Notice of Non-Covered Services* ("NCS Form"). If you are (or become) Medicare eligible and choose not to sign our NCS Form, your membership will be automatically terminated, and any unearned Monthly Fee will be refunded to you.

8. Termination. Both you and Practice shall have the absolute and unconditional right to terminate this Agreement, without cause.

a. While we value your membership, you are under no obligation to continue receiving Services and you may terminate this Agreement by providing written notice to the Practice. However, if you later wish to re-enroll with the Practice, a Re-Enrollment Fee and a 9 month pause in re-enrollment may apply as described below.

b. If you choose to terminate this Agreement, please provide your written notice at least 5 days before the end of your billing cycle. If you do not provide at least 5 days' notice, then your membership will terminate on the last day of the next month following receipt of your notice of termination by the Practice, and Fees for the billing cycle will be due accordingly.

c. Any unearned prepaid Monthly Fees will be returned to you within 30 days of termination of this Agreement.

d. Notwithstanding any other provision of this Agreement, if your decision to terminate is based on a grievance with the Practice, you will give us an opportunity to make it right, prior to issuing your written notice of termination or taking other action.

e. If the Practice elects to terminate this Agreement, the Practice will provide you with 30 days' written notice, or any such other time necessary to transition your care to another provider, in accordance with the laws of the State of Florida.

f. There are certain circumstances in which the Practice may choose to immediately terminate this Agreement. Such circumstances may include, but are not limited to:

    i. If you miss two (2) consecutive payments of the Monthly Fee.

    ii. Failure to pay Itemized Charges when they are due.

    iii. Failure to sign required documentation, as applicable.

iv. You have performed an act that constitutes fraud.

v. You fail to adhere to the recommended treatment plan, especially regarding the use of controlled substances.

vi. You are disruptive, abusive, or present an emotional or physical danger to the wellbeing of the staff or other patients of Practice.

vii. The Practice discontinues operation.

Re-Enrollment. If you choose to discontinue your membership you will be subject to a 9-month pause prior to re-enrollment. If you later wish to re-enroll, the Practice reserves the right to decline re-enrollment or require you to pay a re-enrollment fee of **$250**.

9. Privacy & Communications.

a. Your Privacy Rights. You acknowledge and hereby authorize the Practice to use and/or disclose your health information which specifically identifies you, or that can reasonably be used to identify you, to carry out your treatment, payment, and healthcare operations. The Practice will adhere to its obligations regarding your privacy rights as identified in the Practice's *Notice of Patient Privacy Practices*.

b. Methods of Communication. You acknowledge that the Practice communications may include e-mail, facsimile, video chat, instant messaging, and cell phone (collectively, "Communications"). Communications by their nature cannot be guaranteed to be secure or confidential. If you initiate a conversation in which you disclose Private Health Information (PHI) on any of these Communication platforms, then you authorize the Practice to communicate with you regarding all PHI in the same format.

10. Miscellaneous.

a. Amendment. No amendment or variation of the terms of this Agreement shall be valid unless in writing and mutually agreed to by both parties.

b. Anti-Referral Laws. Nothing in this Agreement, nor any other written or oral agreement, nor any consideration in connection with this Agreement, contemplates, requires, or is intended to induce or influence the admission or referral of any patient to, or the generation of any business between, the parties or any other entity. This Agreement is not intended to influence any Provider's professional judgment in choosing the appropriate care and treatment of patients.

c. Dispute Resolution. The parties shall endeavor to amicably resolve any disputes arising under this Agreement. If such internal resolution is not effective, each party agrees to participate in good faith mediation in order to resolve the dispute. If mediation is unsuccessful, each party agrees that final disposition of the dispute shall be resolved by binding arbitration and enforced by any court of competent jurisdiction. The provider of arbitration services shall be determined by the Practice. Notwithstanding anything to the contrary, small claims court actions brought by the Practice shall be exempt from the requirements of this provision.

d. Governing Law. This Agreement shall be subject to and governed by the laws of Florida without regard to any conflicts of law provisions therein contained and the parties specifically waive any and all jurisdictional rights under the laws of any other state.

e. Grammar and Headings. Wherever the context may require, any pronouns used in this Agreement shall include the corresponding masculine, feminine, or neuter forms, and singular and plural nouns shall include the

corresponding form. The captions and headings for each provision of this Agreement are included for convenience of reference only and shall not be deemed to modify, restrict, or enlarge any of the terms or provisions of this Agreement.

f. Integration. This Agreement constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes any and all other oral or written agreements, representations, negotiations, and understandings.

g. Notices. Any notices or payments required or permitted to be given under this Agreement shall be deemed given when in writing, by electronic transmission, hand delivered, or delivered by traceable carrier with postage prepaid, to the other party at the designated addresses. All notices shall be deemed delivered as evidenced by verified date stamp.

h. Notice to Consumers. Medical doctors are licensed and regulated by the Florida Board of Medicine available by telephone at (850) 488-0595 or online at www.flboardofmedicine.gov

i. Remedies. All powers, remedies, and rights ("Remedies") granted to the Practice by any particular term of this Agreement are cumulative and in addition to, but not in limitation of, any Remedies that it has under any other term of this Agreement, at common law, in equity, by statute, or otherwise. All such Remedies may be exercised separately or concurrently, in such order and as often as may be deemed expedient by the Practice.

j. Severability. In the event that any provision of this Agreement is held to be illegal or unenforceable for any reason, the unenforceability of that provision shall not affect the remainder of this Agreement, which shall remain in full force and effect in accordance with its terms, and any offending provision shall be rectified to the minimum extent necessary for conformity with law unless it cannot be rectified in which case this Agreement shall be interpreted as though the offending provision had not existed.

If this Agreement is held to be invalid or unenforceable for any reason, and if the Practice is therefore required to refund all or any portion of the Fees paid by you, you agree to pay the Practice an amount equal to the fair market value of the Services actually rendered to you during the period of time for which the refunded fees were paid, commensurate with prevailing rates in the Practice area.

k. Valid Payment. You are required to keep a valid form of payment on file with the Practice at all times pursuant to the attached payment authorization form. If the form of payment provided expires or otherwise becomes invalid, you agree to promptly provide the Practice with updated payment information. You further agree to pay for any costs associated with invalid payments or payment information, including but not limited to insufficient funds or chargeback fees.

l. Waiver. No waiver of a breach of any provision of this Agreement will be construed to be a waiver of this Agreement, or any other provision herein contained, whether of a similar or different nature, and no delay in acting with regard to a breach shall be construed as a waiver of that breach.

PATIENT ACKNOWLEDGEMENTS

Please read each line carefully and initial to indicate your agreement with the statement.

You acknowledge that this Agreement is not a contract that provides health insurance. You further acknowledge that the Practice has advised you to maintain health insurance for coverage for all healthcare services not specifically provided for in this Agreement. You acknowledge that the Practice will not file or issue any claims for reimbursement on your behalf, including claims to Medicaid or Medicare. You acknowledge that the Practice and its Physicians have elected "opt out" status of Medicare participation.

_____ You acknowledge that managed care plans like HMOs and EPOs generally do not authorize or pay for ancillary services or specialist referrals ordered by the Practice.

_____ You acknowledge that you do not have an emergent medical problem at this time. In the event of a medical emergency, you agree to call 911 first.

_____ You attest that you have read, understand, and agree to our *Notice of Patient Privacy Practices* and that you have been given a copy of the Notice or opted to use a digital copy.

_____ With regards to dispensed medications, you acknowledge that you have a choice between obtaining the prescription from the dispensing Physician or obtaining the prescription at a pharmacy of your choice.

Your signature below means that you have read, understand, and agree to all of the terms contained in this Agreement. If you are enrolling other members, your signature means that you have the authority to act on their behalf and you are financially responsible for Services they receive under this Agreement.

_____

Signature Date

Name of Enrolled Member	Date of Birth

Medicare Beneficiary Name:
Medicare ID:
Beneficiary Address:
Legal Representative: **(If applicable)**

MEDICARE BENEFICIARY PRIVATE CONTRACT AND NOTICE OF NON-COVERED SERVICES

This Medicare Beneficiary Private Contract and Notice of Non-Covered Services is made by and between Salameh Family Care, a Florida professional medical corporation, doing business as Salameh Family Care ("Practice") and the individual listed above ("Patient" or "Beneficiary") and is incorporated by reference to that certain Patient Agreement made by and between the parties as though fully set forth therein. Patient is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. Practice has informed Beneficiary or his/her legal representative that Physicians at the Practice have opted out of the Medicare program. Physicians of the Practice have not been excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 of the Social Security Act. Beneficiary or his/her legal representative agrees, understands, and expressly acknowledges the following:

Please read each line carefully and initial to indicate your agreement with the statement.

_____ I want the services provided by the Practice and its physicians. I understand that Medicare will not be billed for these services and that I cannot appeal if Medicare is not billed.

_____ I accept full responsibility for payment of all charges for all services furnished by the Practice and its physicians.

_____ I understand that Medicare limits do not apply to what the Practice may charge for items or services furnished by the Practice and its physicians.

_____ I agree not to submit a claim to Medicare or to ask the Practice or its physicians to submit a claim to Medicare.

Patient Name: _____

_____ I understand that Medicare payment will not be made for any items or services furnished by the Practice and its physicians that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_____ I am entering into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

_____ I understand that my physician has elected for a rolling opt-out period and that there is no expected expiration date of the opt-out period.

_____ I understand that Medigap plans do not make payments for items and services not paid for by Medicare, and that other supplemental plans may elect not to make payments for items and services not paid for by Medicare.

_____ I acknowledge that I am not currently in an emergency or urgent health care situation.

_____ I acknowledge that I have been given a copy of this contract prior to services being rendered.

Executed On: _____

By: _____
Signature of Medicare Beneficiary or his/her legal representative

And: _____
Signature for Salameh Family Care

General Information:

Please provide the following information for our clinic. Insurance information is only for information for specialty and laboratory referrals and other outside orders.

Patient Name: _____

Date of Birth: _____

Responsible Party: ☐ Self Other: _____

Address: _____
_____
_____

Insurance Provider (or you can attach a copy of your card):
Plan: _____
Group Number: _____ Effective Date: _____
ID Number: _____
Claims Address: _____
_____

Contact Preference: ☐ Cell phone: _____
☐ Home phone: _____

Email address: _____
Work phone: _____

Emergency Contact: _____
Phone: _____
Relationship to patient: _____

Recurrent Billing Information:

Please complete if you have not submitted information on the website for recurrent billing, and we will help to set up the account for you on your first visit.

Name on Account: _____

Membership Plan: (# of Patients)
☐ Individual ($99) _____
☐ Family up to 4 members($129) _____
☐ Additional children ($49) _____

Method of Payment: ☐ Checking ☐ Savings
Account number: _____
Routing number: _____

OR -- Method of Payment: ☐ Visa ☐ MasterCard ☐ American Express
Account number: _____
Expiration date: _____CVV#_____
Zip code associated with card:_____

Billing Address: ☐ Same as above
☐ Other: _____
_____

Patient History Form

Name:	DOB:
Partner:	Occupation:

Medications (including prescriptions, non-prescriptions, vitamins and supplements) ☐ No current medications

Allergies to Medications (including latex, or known allergens) ☐No known drug allergies

Surgeries, Hospitalizations, Serious Injuries	Year

Medical History (please check if positive)

	ENT		PULMONARY		GASTROINTESTINAL cont.
	Eye problems		Asthma		Blood in stool
	Allergies/hay fever		Emphysema		Black stool
	Sinus problems		COPD		Hemorrhoids
	Hearing loss		Sleep Apnea		Constipation
			Pneumonia		Diarrhea
	CARDIOVASCULAR		Chronic bronchitis		Hepatitis
	Abnormal EKG		Shortness of breath		Pancreatitis
	Angina				
	Chest pain		GASTROINTESTINAL		GENITOURINARY
	Prior heart attack		Acid Reflux		Chronic urinary infections
	Heart disease		Barrett's esophagitis		Kidney disease
	High blood pressure		History of EGD		Kidney stones
	High cholesterol		Irritable Bowel		Urinary incontinence
	Stroke		Gall bladder problems		Erectile dysfunction
	Peripheral Vascular Disease		Liver disease		Sexually transmitted diseases
	Murmur/heart valve problems		Inflammatory bowel disease		
			Change in bowel habit		

Name:_____ DOB: _____

Medical History Continued

	MUSCULOSKELETAL		HEMATOLOGICAL		SKIN
	Osteoarthritis (joints involved)		Anemia		Eczema
			Bleeding disorders		Psoriasis
			Clotting disorders (DVT history)		Atopic Dermatitis
	Rheumatoid Arthritis		Sickle Cell disease/trait		Melanoma
	Gout		Blood cancers		Squamous cell cancer
	Fibromyalgia		Blood Transfusions (#)		Basal cell cancer
	Muscle disease				
	Spinal disease, stenosis				
			NEUROLOGICAL		PSYCHIATRY
	ENDOCRINE		Chronic Headaches		Depression
	Diabetes		Migraines		Memory Loss
	Thyroid disease		Epilepsy/Seizures		Anxiety
			Radiculopathy		Suicidal thoughts/attempt
			Peripheral Neuropathy		OCD
	OTHER		Concussion		

Gynecological History	OB History
Age periods started:	Number of pregnancies:
Menopause? ☐Yes ☐No If so, at what age:	Number of deliveries:
Regular cycles? ☐Yes ☐No	Miscarriages:
Abnormal pap in the past? ☐Yes ☐No If so, when:	Terminations:
Problems with cycles?	Birth control method:
History of STDs?	

Health Maintenance	Yes	No	Date/Year		Yes	No	Date/Year
Colonoscopy				Bone Density			
Abdominal Ultrasound				Last Eye Exam			
Mammogram				Last Labs			
Pap Smear				Complete Physical Exam			

Immunization History	Yes	No	Date/Year		Yes	No	Date/Year
Pneumovax (pneumonia vaccine)				Hepatitis vaccines ☐A series ☐B series			
Prevnar (new pneumonia vaccine)				Meningitis Vaccine			
Zostavax (Shingles vaccine)				Last MMR (Measles vaccine)			
Last Influenza Vaccine				Gardasil Series (HPV vaccine)			
Tdap (tetanus/whooping cough) Or Td (tetanus) booster				History of Chickenpox or Vaccine			
Last TB (tuberculosis) testing				Other:			

Social History	Yes	No		
Tobacco Use			Packs/day: # of years:	☐ Quit Year:
Alcohol			Drinks per day/week/month:	Type of alcohol:

Name:_____ DOB: _____

Social History Continued	Yes	No	
Caffeine			Type/Cups per day:
Recreational Drugs or history			
Intravenous Drugs or history			
Difficulty with sleep			# of hours per night:
Special Diet			If yes, describe:
Sexually Active			Partner:
Exercise			Describe activity/time/#per week:

Family History

Medical Illness	Mother	Father	Sibling	MGM	MGF	PGM	PGF	Child	Other
Alzheimer's Disease									
Asthma									
Bleeding Disorders									
Breast Cancer									
Colon Cancer									
COPD/Emphysema									
Dementia									
Depression/Anxiety									
Diabetes									
Drug/Alcohol Addiction									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Kidney Disease									
Leukemia									
Liver Disease									
Lung Cancer									
Osteoporosis									
Ovarian Cancer									
Pancreatic Cancer									
Prostate Cancer									
Rheumatoid Arthritis									
Stroke									
Thyroid Disease									
Other									

Other Information that we should know: _____
_____
_____
_____
_____

Thank you!

NOTICE OF PATIENT PRIVACY PRACTICES

Effective **July 2021**

Salameh Family Care has developed this Notice of Patient Privacy Practices to help you understand how medical information about you may be used, disclosed, and how you can get access to this information. **Please review this notice carefully.**

YOUR RIGHTS

You have the right to:

- Get a copy of your paper or electronic medical record.
- Correct your paper or electronic medical record.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a list of those with whom we've shared your information.
- Get a copy of this privacy notice.
- Choose someone to act for you.
- File a complaint if you believe your privacy rights have been violated.

YOUR CHOICES

You have some choices in the way that we use and share information if we:

- Tell family and friends about your condition.
- Provide disaster relief.
- Include you in a hospital directory.
- Provide mental health care.

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Treat you.
- Run our practice.
- Bill for your services.
- Help with public health and safety issues.
- Do research.
- Comply with the law.
- Respond to organ and tissue donation requests.
- Work with a medical examiner or funeral director.
- Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions.

- If you are or become incapacitated, we may disclose relevant medical information to a family member, other relative, domestic partner, a close personal friend of yours, or any other person identified by you as having involvement in your care or payment for your care.
- All medical information transmitted during the delivery of health care via telehealth/telemedicine/virtual care will become a part of your medical records.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains those rights.

Ask to see a copy of your medical record. If you would like to see a copy of your medical records, just let us know. We will grant your written request during business hours within 5 working days of the request. The records can be viewed by you or your personal representative, and either you or the representative may bring one person of your choosing.

Get an electronic or paper copy of your medical record.

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy of your health information, usually within 15 days of your request. We may charge a reasonable, cost-based fee of $0.25 per page.
- If your request for a copy is for the purpose of supporting a claim or appeal for public benefits, then the fee will be waived and one free copy will be provided within 30 days.
- In lieu of access to the entire record, we may instead provide a summary including your medication list, within 10 working days of your request, unless your record is lengthy, then we may need additional time, not to exceed 30 days. We may charge a reasonable fee for the time it takes to prepare the summary.
- If your medical records include mental health records, we may decline to provide access to these records if we feel there is a substantial risk of significant adverse or detrimental consequences of such access. However, we will release those records to a qualified professional.

Ask us to correct your medical record.

- You can ask us to correct health information about you that you think is incorrect or incomplete. If you wish, you can write an addendum of up to 250 words per incorrect or incomplete item; this addendum will be added to your medical records and will clearly indicate in writing that you request the addendum to be made a part of your records.

Request confidential communications.

- You can ask us to contact you in a specific way (for example, home or office phone), or to send mail to a different address.
- We will agree to reasonable requests.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it could affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information.

- You can ask for a list (an accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

- Please let us know if you feel we have not upheld our obligations. Contact us using the information on page 1 of this Notice.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and the choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes.
- Most sharing of psychotherapy notes.

In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways:

- We never market or sell personal information.
- We can use your health information and share it with other professionals who are treating you.
- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- We can use and share your health information to bill and get payment from health plans or other entities.

We are allowed or required to share your information in other ways, usually in ways that contribute to the public good. [*]We have to meet many legal obligations before we can share your information for these purposes that include:

Government Requests: We can use or share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.

[*] For more information visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

- For special government functions such as military and national security.

Legal Actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Legal Compliance: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Medical Examiners & Funeral Directors: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Organ and Tissue Donation: We can share health information about you with organ procurement organizations.

Public Health & Safety:

- Preventing disease.
- Helping with product recalls.
- Reporting adverse reactions to medications.
- Reporting suspected abuse, neglect, or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety.

Research: We can use or share your information for health research.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.[**]
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described in this Notice, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

[**] For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: _____
Date of Request: _____

Record from Provider: _____
Address of Provider: _____
_____

Records Being Requested:

___All Clinical Records ☐All Dates ☐Specific Date(s): _____

___Emergency Department Records
___Discharge Summary
___History and Physical
___Physician Notes
___Health Maintenance Records
___Imaging Results
___Specific Information as follows: _____

___Operative Reports
___Pathology Reports
___Laboratories/Test Results
___Medication Lists

___Please DO NOT release the following records:
_____Behavioral Health Records/Psychiatric Records
_____HIV Status
_____Drug or Alcohol Treatment Programs
_____Other_____

Please send the above information to:

Signature of Patient/Legal Representative: _____
Person Requesting Records (if not the patient): _____
Relationship: _____

Home Phone: _____ Daytime Phone: _____
Expiration of Authorization, if indicated (date)_____

Your rights with respect to this Authorization: I am aware that I have the right to inspect and receive a copy of the health information I have authorized by this agreement. I understand that I may be charged a fee for record copies. I understand that I do not need to sign this authorization in order to receive treatment. I also am aware that I may revoke this authorization in writing, however, I understand that my revocation will not be effective as the to uses and disclosures already made in reliance upon the authorization. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure.

Date Faxed:
Date Record Received:
MD for review: