PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

LAST NAME: ________________________ FIRST NAME: ________________________ MI: ________

DATE OF BIRTH: __________________ (mm/dd/yyyy) SEX: __________ RACE: ________________

SOCIAL SECURITY #:________________________________ ETHNICITY: _____________________

ADDRESS 1: _________________________________ ADDRESS 2: ______________________________

CITY: _________________________ STATE:____________ ZIP: __________________

LANGUAGE: __________________ LANGUAGE COUNTRY:______________________________

MARITAL STATUS: SINGLE MARRIED PARTNER DIVORCED WIDOWED

PREGNANT (check if applicable) NURSING (check if applicable) Whom may we thank for referring you to our practice? ____

CONTACT INFORMATION

HOME PHONE: ____________________ WORK PHONE: ______________________ EXT:_____

CELL PHONE: __________________________ EMAIL: ______________________________________

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _______________________ CONTACT LAST NAME: _______________________

CONTACT HOME PHONE: _______________________ CONTACT CELL PHONE: _____________________

RELATIONSHIP TO PATIENT: _________________ CONTACT ADDRESS: __________________________

CITY: _________________________ STATE: ________________ ZIP: _______________________

FAMILY MEMBERS IN THE PRACTICE

_____________________ (name) ______________________ (relationship to patient)
_____________________ (name) ______________________ (relationship to patient)
_____________________ (name) ______________________ (relationship to patient)
_____________________ (name) ______________________ (relationship to patient)

PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME: _______________________ PRACTICE NAME: ____________________________

ADDRESS: _____________________ CITY: __________________ STATE: __________ ZIP: __________

PHARMACY NAME: ______________________________ PHARMACY PHONE: ______________________

PHARMACY LOCATION: ____ **By signing below, I attest that the information provided above is true and accurate**

Signature of Insured / Guardian: ___________________________________ Date: ___________________

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

____
Last First Middle

OTHER NAME(S) USED ______________________________

DATE OF BIRTH Month __________Day __________ Year______________

ADDRESS ____

____

CITY ___________________________**STATE**_______ **ZIP**______________

PHONE (_____)_____________ **ALT. PHONE** (_____)________________

EMAIL ADDRESS (Optional): ______________________________

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name ____
Address ____
City ______________________________________ State ________ Zip Code __________
Phone (_______)___________________Fax (_______)____________________________

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name ____
Address ____
City ______________________________________ State ________ Zip Code __________
Phone (_______)___________________Fax (_______)____________________________

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other ________________________

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

☐ **All health information**	☐ History/Physical Exam	☐ Past/Present Medications	☐ Lab Results
☐ Physician's Orders	☐ Patient Allergies	☐ Operation Reports	☐ Consultation Reports
☐ Progress Notes	☐ Discharge Summary	☐ Diagnostic Test Reports	☐ EKG/Cardiology Reports
☐ Pathology Reports	☐ Billing Information	☐ Radiology Reports & Images	☐ Other________________

Your initials are required to release the following information:

______Mental Health Records (excluding psychotherapy notes)
______Drug, Alcohol, or Substance Abuse Records
______Genetic Information (including Genetic Test Results)
______ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _________ Day __________ Year _________

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X____ ________________________
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): ______________________________
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other ________________

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X____ ________________________
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY: ___________________________________ CO-PAY: ________________________

GROUP #: ___________________________________ SUBSCRIBER #: ________________________________

INSURED FIRST NAME: _______________________ LAST NAME: _________________________ MI: ______

SOCIAL SECURITY #: ___________________ DOB: ____________ RELATION TO PATIENT: ___________

ADDRESS: _____________________ CITY:_______________________ STATE: _______ ZIP: ___________

PHONE #: _________________ EXT: ______

ADVANCED DIRECTIVE? YES NO WHERE IS IT FILED? __________________(what medical facility?)

INSURED EMPLOYED BY: _________________________ BUSINESS ADDRESS: ____________________

CITY: _______________ STATE _____ ZIP:__________ BUSINESS PHONE #: ________________________

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? YES NO

INSURANCE COMPANY: ___________________________________ CO-PAY: ________________________

GROUP #: ___________________________________ SUBSCRIBER #: ________________________________

INSURED FIRST NAME: _______________________ LAST NAME: _________________________ MI: ______

DOB: ____________ RELATION TO PATIENT: ___________ ADDRESS: _____________________________________

CITY:_______________________ STATE: _______ ZIP: ___________

PHONE #: ____________________________ EXT: ________

INSURED EMPLOYED BY: ____

BUSINESS ADDRESS: ____________________ CITY: _______________ STATE _____ ZIP:______________

BUSINESS PHONE # : _____________________________________

EMPLOYMENT STATUS: Employed Unemployed Full Time Student Part Time Student Retired

LAST DEGREE EARNED: HIGH SCHOOL COLLEGE GRADUATE SCHOOL OCCUPATION: _

BUSINESS NAME: _________________________________ BUSINESS PHONE:_____________________

DRIVERS LICENSE #: _______________________ STATE ISSUED: _____________

IS THIS AN ACCIDENT? YES NO IS THIS A MOTOR VEHICLE ACCIDENT? YES NO DATE OF INJURY__________

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT By signing below, I attest that the information provided above is true and accurate

Signature of Insured/Responsible Party_____________________________________ Date: _____________

Authorization to release or use information for treatment, payment, or health care operations I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by ____________________________ in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to releasing information to me in the following manners:

VIA MAIL PLEASE INITIAL

OK TO MAIL TO HOME ADDRESS _______________

OK TO MAIL TO WORK ADDRESS _______________

VIA HOME TELEPHONE

OK TO LEAVE DETAILED MESSAGE ______________

LEAVE CALL BACK NUMBER ONLY ______________

VIA WORK TELEPHONE

OK TO LEAVE DETAILED MESSAGE ______________

LEAVE CALL BACK NUMBER ONLY ______________

VIA FAX OK TO FAX TO: ___________________ ______________

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____________________________________ Date: ___________________

Types of Appointments Offered at Modera Clinic

- **Wellness Visits, Annual Check up, Annual Physical**
    - Insurance cover these 100% one time per year
    - Typically screening blood work, diet and exercise recommendations, and other targeted cancer screenings are performed at these visits.
    - All blood work is drawn at our facility.
    - Appointments are typically 30 minutes long
- **Acute care, Urgent Care appointments**
    - These are subject to your copay and/or deductible
    - Acute infections, chest pain, difficulty breathing, urinary complaints, etc...
    - These appointments are typically 10-15 minutes long
- **Chronic Disease Appointments**
    - These are subject to your copay and/or deductible
    - Monitoring for effectiveness and possible side effects of medicines taken every day
    - Monitoring for complications and control of chronic diseases
    - These appointments are typically 10-15 minutes long
- **Electronic Visits, E-Visits, Telemedicine, Telehealth**
    - Are intended for low complexity health issues
    - Are currently not covered by insurance
    - Are performed via your patient portal with your primary care physician
    - May be performed after hours to avoid needing to go to an Urgent Care or ER

Signature: ____ Date: ________________

Modera Clinic Payment Policy

Thank you for choosing us as your Primary Care Provider. We are committed to providing you with quality and affordable health care. Please read this document thoroughly, ask us any questions you may have about it, and sign in the space provided or confirm receipt electronically. A copy will be provided to you upon request.

- **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in-full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage, we do our best to confirm your benefits before your appointment. We collect payment, at time of service, based upon the benefits that we are able to confirm with your insurance company.

- **Copayments and deductibles.** All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment or deductible at each visit.

- **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be "non-covered" or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in-full at the time of visit. Examples of, but not limited to, are forms that are requested to be completed by the patient, no-show fees, sports physicals, etc…

- **Office Visits with Annual Wellness Exams**: Most insurance companies offer a wellness exam at no-cost to you, once per year. During these visits we will discuss general health and screenings with you. We will also order routine blood work, which we can obtain in-house. If during your visit, you and the Provider discuss any ailments or issues outside of Routine Annual Exam codings, your doctor must document these issues as they are assuming care of these issues as your Provider and your Provider may also refill or prescribe medications to you. This will result in coding for an Office Visit as this documentation is outside of routine coding. These Office Visit codes are subject to your copay or deductible plan.

- **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of your claim.

- **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If you believe you have received a bill in error, or your insurance has not processed your claim consistent with your insurance coverage,

please contact your insurance company FIRST before contacting us and discussing the bill. Many times we may need to re-submit the claims and will do this for you if you provide us with the necessary information to do so. Please be patient with us as we work with you to ensure your insurance company is processing your claims correctly. We have seen many instances of patient's insurance claims that are processed incorrectly multiple times by the insurance company. Once this exceeds 3 months we ask that you pay the balance and file a complaint, either with your employer or the Texas Department of Insurance, as well as submit your receipt of payment to your insurance provider and your human resources department to receive reimbursement. We will assist you with any documentation that you may require.

- **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.

- **Invoices**. You will receive automatic invoices via your Patient Portal as well as invoices via Postal Service. We will NOT provide services, including but not limited to, office visits, phone messages, patient portal messages, and/or prescription refills until your balance has been paid in-full.

- **Outside Services Bills.** Please understand that your insurance company does not share with us the cost of medications and other services such as labs and imaging services. Cost varies by insurance and facility. Please do not contact us about bills that you receive from outside facilities, as this is outside of our control.

- **Non-payment.** If your account is over 90 days past-due, we will send your account to a contracted collections agency. Partial payments will not be accepted unless otherwise negotiated.

- **Missed appointments.** Our policy is to charge $30.00 for missed appointments not canceled 2 hours in advance of appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
- **Chronic Care Management.** As a Primary Care Physician, we provide many services even when you are not in the clinic by coordinating your care with other providers. Your insurance allows us to bill for these services when we spend more than 20 minutes each month. As one of our patients, we require that you consent to us providing these services as needed. By not allowing us the ability to provide these services to you, it could negatively affect your health and possibly result in serious morbidity and mortality.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

______________________________________ ______________

Signature of patient or responsible party **Date**

Modera Clinic Communication Policies

1. Ways we communicate with you

a. Via our office phone at 972-987-0458

b. Via our physician after hours on call line at 940-489-2694 c. Via our patient portal using our messaging features d. Via text to your personal mobile phone

e. Via Email

f. Via our care coordinators at Catalyst Health Network

2. Ways we may communicate confidential health information which are compliant with federal and state laws

a. We may communicate your test results either via phone or via your patient portal.

b. Via phone

c. Via your patient portal

3. Ways we CAN NOT communicate confidential health information, unless verbally and/or written consent is given by the patient

a. Via text message

b. Via e-mail

4. Ways you can schedule appointments

a. Calling our office during office hours

b. Via your patient portal 24/7

c. On our website at ModeraClinic.com/contact

5. Non-Emergency After Hours On Call Physician

a. On Call Physician number: 469-803-8714

b. This is for urgent but non-emergencies only, emergency calls should be directed to 911

c. Please call the on-call number and when prompted leave a voice message with your name, date of birth, reason for the call, and a call back number

d. One of our physicians will call you back within 2-3 hours

e. You may be directed to perform an e-visit via your patient portal with the physician which is subject to your copay or deductible.

6. Test Results

a. Please allow 3-5 business days for us to contact you with test results.

b. Depending on the tests ordered, it may take longer than 3-5 business days for use to receive test results as this is dependent on other entities and physicians to communicate these results with us.

c. Patient Portal: All tests results as well as a detailed message explaining the results

will be posted to your portal and you will receive an email stating that you have results and/or messages ready to be reviewed.

d. Nurse Call: Our nurses will call you and inform you of the test results along with the physicians explanation of the results. e. Voicemail and/or text: We may inform you via voicemail and/or text message that you have results which are ready.

7. Forms Requested to be Completed by Physician

a. Include, but not limited to, FMLA paperwork, Disability paperwork, Handicap paperwork, Life Insurance paperwork, Disability Insurance paperwork, etc…

b. All forms requested to be completed by the patient are subject to an $36.00 fee which must be paid by the patient and may not be billed to your health insurance company.

c. Please allow 3-5 business days to be completed and returned to you

d. All completed forms will be placed on your patient portal for you to download.

e. You may also request forms to be faxed, copies made for you to pick up at the clinic, or for forms to be mailed for a separate processing and mailing fee.

Signature: ____________________________________ Date: _____________

HIPAA Omnibus Notice of Privacy Practices

Effective Date: 10/23/2017 Revised on:

Modera Clinic pllc

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

This Notice of Privacy Practices is NOT an authorization. It describes how we, our Business Associates, and their subcontractors may use and disclose your Protected Health Information to carry out treatment, payment, or health care operations, 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 that identifies you individually, including demographic information that relates your past, present, or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your Protected Health Information in the following situations:

- **Treatment:** We may use or disclose your Protected Health Information to provide medical treatment and/or services in order to manage and coordinate your medical care. For example, we may share your medical information with other physicians and health care providers, DME vendors, surgery centers, hospitals, rehabilitation therapists, home health providers, laboratories, nurse case managers, worker's compensation adjusters, etc. to ensure that the medical provider has the necessary medical information to diagnose and provide treatment to you.

- **Payment:** Your Protected Health Information will be used to obtain payment for your health care services. For example, we will provide your health care plan with the information it requires prior to paying us for the services we have provided to you. This use and disclosure may also include certain activities that your health plan requires prior to approving a service, such as determining benefits eligibility and prior authorization, etc.

- **Health Care Operations:** We may use and disclose your Protected Health Information to manage, operate, and support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, licensing, fundraising, and conducting or arranging for other business activities. 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 physician. We may also call you by name in the waiting room when your physician 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.

- **Minors:** Protected Health Information of minors will be disclosed to their parents or legal guardians, unless prohibited by law.

- **Required by Law:** We will use or disclose your Protected Health Information when required to do so by local, state, federal, and international law.

- **Abuse, Neglect, and Domestic Violence:** Your Protected Health Information will be disclosed to the appropriate government agency if there is belief that a patient has been or is currently the victim of abuse, neglect, or domestic violence and the patient agrees or it is required by law to do so. In addition, your information may also be disclosed when necessary to prevent a serious

threat to your health or safety or the health and safety of others to someone who may be able to help prevent the threat.

- **Judicial and Administrative Proceedings:** As sometimes required by law, we may disclose your Protected Health Information for the purpose of litigation to include: disputes and lawsuits; in response to a court or administrative order; response to a subpoena; request for discovery; or other legal processes. However, disclosure will only be made if efforts have been made to inform you of the request or obtain an order protecting the information requested. Your information may also be disclosed if required for our legal defense in the event of a lawsuit.

- **Law Enforcement:** We will disclose your Protected Health Information for law enforcement purposes when all applicable legal requirements have been met. This includes, but is not limited to, law enforcement due to identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or warrant, and grand jury subpoena.

- **Coroners and Medical Examiners:** We disclose Protected Health Information to coroners and medical examiners to assist in the fulfillment of their work responsibilities and investigations.

- **Public Health:** Your Protected Health Information may be disclosed and may be required by law to be disclosed for public health risks. This includes: reports to the Food and Drug Administration (FDA) for the purpose of quality and safety of an FDA-regulated product or activity; to prevent or control disease; report births and deaths; report child abuse and/or neglect; reporting of reactions to medications or problems with health products; notification of recalls of products; reporting a person who may have been exposed to a disease or may be at risk of contracting and/or spreading a disease or condition.

- **Health Oversight Activities:** We may disclose your Protected Health Information to a health oversight agency for audits, investigations, inspections, licensures, and other activities as authorized by law.

- **Inmates:** If you are or become an inmate of a correctional facility or under the custody of the law, we may disclose Protected Health Information to the correctional facility if the disclosure is necessary for your institutional health care, to protect your health and safety, or to protect the health and safety of others within the correctional facility.

- **Military, National Security, and other Specialized Government Functions:** If you are in the military or involved in national security or intelligence, we may disclose your Protected Health Information to authorized officials.

- **Immunizations:** We will provide proof of immunizations to a school that requires a patient's immunization record prior to enrollment or admittance of a student in which you have informally agreed to the disclosure for yourself or on behalf of your legal dependent.

- **Worker's Compensation:** We will disclose only the Protected Health Information necessary for Worker's Compensation in compliance with Worker's Compensation laws. This information may be reported to your employer and/or your employer's representative regarding an occupational injury or illness.

- **Practice Ownership Change:** If our medical practice is sold, acquired, or merged with another entity, your protected health information will become the property of the new owner. However, you will still have the right to request copies of your records and have copies transferred to another physician.

- **Breach Notification Purposes:** If for any reason there is an unsecured breach of your Protected Health Information, we will utilize the contact information you have provided us with to notify you of the breach, as required by law. In addition, your Protected Health Information may be disclosed as a part of the breach notification and reporting process.

- **Research:** Your Protected Health Information may be disclosed to researchers for the purpose of conducting research when the research has been approved by an Institutional Review or Privacy Board and in compliance with law governing research.

- **Business Associates:** We may disclose your Protected Health Information to our business associates who provide us with services necessary to operate and function as a medical practice. We will only provide the minimum information necessary for the associate(s) to perform their functions as it relates to our business operations. For example, we may use a separate company to process our billing or transcription services that require access to a limited amount of your health information. Please know and understand that all of our business associates are obligated to comply with the same HIPAA privacy and security rules in which we are obligated. Additionally, all of our business associates are under contract with us and committed to protect the privacy and security of your Protected Health Information.

USES AND DISCLOSURES IN WHICH YOU HAVE THE RIGHT TO OBJECT AND OPT OUT

- **Communication with family and/or individuals involved in your care or payment of your care:** Unless you object, disclosure of your Protected Health Information may be made to a family member, friend, or other individual involved in your care or payment of your care in which you have identified.

- **Disaster:** In the event of a disaster, your Protected Health Information may be disclosed to disaster relief organizations to coordinate your care and/or to notify family members or friends of your location and condition. Whenever possible, we will provide you with an opportunity to agree or object.

- **Fundraising:** As necessary, we may disclose your Protected Health Information to contact you regarding fundraising events and efforts. You have the right to object or opt out of these types of communications. Please let our office know if you would NOT like to receive such communications.

USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

We will not disclose or use your Protected Health Information in the situations listed below without first obtaining written authorization to do so. In addition to the uses and disclosures listed below, other uses not covered in this Notice will be made only with your written authorization. If you provide us with authorization, you may revoke it at any time by submitting a request in writing:

- **Disclosure of Psychotherapy Notes:** Unless we obtain your written authorization, in most circumstances we will not disclose your psychotherapy notes. Some circumstances in which we will disclose your psychotherapy notes include the following: for your continued treatment; training of medical students and staff; to defend ourselves during litigation; if the law requires; health oversight activities regarding your psychotherapist; to avert a serious or imminent threat to yourself or others; and to the coroner or medical examiner upon your death.

- Disclosures for marketing purposes and sale of your Protected Health Information

PROTECTED HEALTH INFORMATION AND YOUR RIGHTS

The following are statements of your rights, subject to certain limitations, with respect to your Protected Health Information:

- **You have the right to inspect and copy your Protected Health Information (reasonable fees may apply):** Pursuant to your written request, you have the right to inspect and copy your Protected Health Information in paper or electronic format. Under federal law, you may not inspect or copy the following types of records: psychotherapy notes, information compiled as it relates to civil, criminal, or administrative action or proceeding; information restricted by law; information related to medical research in which you have agreed to participate; information obtained under a promise of confidentiality; and information whose disclosure may result in harm or injury to yourself or others. We have up to 30 days to provide the Protected Health Information and may charge a fee for the associated costs.

- **You have a right to a summary or explanation of your Protected Health Information:** You have the right to request only a summary of your Protected Health Information if you do not desire to obtain a copy of your entire record. You also have the option to request an explanation of the information when you request your entire record.

- **You have the right to obtain an electronic copy of medical records:** You have the right to request an electronic copy of your medical record for yourself or to be sent to another individual or organization when your Protected Health Information is maintained in an electronic format. We will make every attempt to provide the records in the format you request; however, in the case that the information is not readily accessible or producible in the format you request, we will provide the record in a standard electronic format or a legible hard copy form. Record requests may be subject to a reasonable, cost-based fee for the work required in transmitting the electronic medical records.

- **You have the right to receive a notice of breach:** In the event of a breach of your unsecured Protected Health Information, you have the right to be notified of such breach.

- **You have the right to request Amendments:** At any time if you believe the Protected Health Information we have on file for you is inaccurate or incomplete, you may request that we amend the information. Your request for an amendment must be submitted in writing and detail what information is inaccurate and why. Please note that a request for an amendment does not necessarily indicate the information will be amended.

- **You have a right to receive an accounting of certain disclosures:** You have the right to receive an accounting of disclosures of your Protected Health Information. An "accounting" being a list of the disclosures that we have made of your information. The request can be made for paper and/or electronic disclosures and will not include disclosures made for the purposes of: treatment; payment; health care operations; notification and communication with family and/or friends; and those required by law.

- **You have the right to request restrictions of your Protected Health Information:** You have a right to restrict and/or limit the information we disclose to others, such as family members, friends, and individuals involved in your care or payment for your care. You also have the right to limit or restrict the information we use or disclose for treatment, payment, and/or health care operations. Your request must be submitted in writing and include the specific restriction requested, whom you want the restriction to apply, and why you would like to impose the restriction. Please note

that our practice/your physician is not required to agree to your request for restriction with the exception of a restriction requested to not disclose information to your health plan for care and services in which you have paid in full out-of-pocket.

- **You have a right to request to receive confidential communications:** You have a right to request confidential communications from us by alternative means or at an alternative location. For example, you may designate we send mail only to an address specified by you which may or may not be your home address. You may indicate we should only call you on your work phone or specify which telephone numbers we are allowed or not allowed to leave messages on. You do not have to disclose the reason for your request; however, you must submit a request with specific instructions in writing.

- **You have a right to receive a paper copy of this notice:** Even if you have agreed to receive an electronic copy of this Privacy Notice, you have the right to request we provide it in paper form. You may make such a request at any time.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this notice and will notify you of such changes. We will also make copies available of our new notice if you wish to obtain one. **We will not retaliate against you for filing a complaint.**

COMPLAINTS

If at any time you believe your privacy rights have been violated and you would like to register a complaint, you may do so with us or with the Secretary of the United States Department of Health and Human Services.

If you wish to file a complaint with us, please submit it in writing to our Privacy/Compliance Officer to the address listed on the first page of this Notice.

If you wish to file a complaint with the Secretary of the United States Department of Health and Human Services, please go to the website of the Office for Civil Rights (www.hhs.gov/ocr/hipaa/), call 202-619-0257 (toll free 877-696-6775), or mail to:

Secretary of the US – Department of Health and Human Services
200 Independence Ave S.W.
Washington, D.C. 20201

Stefanie Huber	972-987-0458	stefaniehuber@moderaclinic.com
HIPAA COMPLIANCE OFFICER	**PHONE**	**EMAIL**

We are required by law to provide individuals with this notice of our legal responsibilities and privacy practices with respect to Protected Health Information. We are also required to maintain the privacy of, and 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 the number listed above.

Signature: ______________________________________ Date: ________________