Dear _____ ,

On behalf of all our providers and staff members, we would like to welcome you to _____ and thank you for entrusting us with your care. Navigating kidney health can be overwhelming, but our team is here to help you through every step of your healthcare journey.

At _____, we take a holistic approach to managing your kidney health. Our goal is to help you better understand your prognosis, work together to proactively manage your disease progression, and provide personalized solutions that fit your lifestyle and needs.

You have been scheduled for an appointment on _____. Your first appointment is an opportunity for you to meet your healthcare provider and share your medical history, as well as for us to get to know you better. During this visit, you and your provider will work together to develop a tailored plan to address your health and wellness needs, as well as determine timing for follow-up visits.

Before your appointment:

To prepare for your first appointment, we ask that you complete the enclosed forms and bring copies with you to your upcoming appointment, along with your insurance card(s) and a current form of photo identification. It's important to also bring either a list of your current medications, or the medications themselves.

On your behalf, we will request your medical information from the referring physician with your permission. Please follow up with your physician's office to have these released.

The day of your appointment:

Please arrive at the office 30 minutes prior to your first visit so we can ensure all the appropriate information is updated in our system. You may also need to give a urine specimen when you arrive in the office.

Our policy is to collect co-payments and co-insurance at the time of service. If you are unable to make payment at the time of service, please contact our office prior to your appointment to make financial arrangements. For your convenience, we accept cash, check, Visa, Mastercard, and American Express.

Thank you for allowing us to be part of your care. We look forward to meeting you soon. If you have any questions or need directions to our office, please contact us directly or visit our website at _____.

Sincerely,

_____

Patient Registration
Please print, complete in full, and make any necessary corrections
USE BLACK or BLUE INK

Current Patient Information	Emergency Contact Information
Last Name:	Name:
First Name:	Relationship:
Middle Name:	Phone:
Address:	Mobile Phone:( ) _____- _____
City:	
Zip:	**Pharmacy Information:**
Home Phone:	Name:
Work Phone:	
Mobile Phone:	Crossroads/Address:
Sex:	
Employer:	Phone:
Date of Birth:	
Social Security No.:	**Other**
Patient email:	Patient Referred by:
Required by government mandate [although you may refuse]:	
• Language:	Primary Care Provider:
• Race:	
• Ethnicity:	Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email
Marital Status:	Contact Preference Detail: _____

Guarantor Information (to whom statements are sent)

Name:

Address:

Relationship to patient: _____

Date of Birth:

Social Security No.:

Phone: ( ) _____- _____

Primary Insurance Information

Insurance Plan Name:

Last Name:

First Name:

Middle Name:

Address:

City: _____State: _____Zip: _____

Date of Birth: Sex (please circle): **M** or **F**

Employer Name:

Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:

Last Name:

First Name:

Middle Name:

Address:

City: _____State: _____Zip: _____

Date of Birth: Sex (please circle): **M** or **F**

Employer Name:

Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Patient Signature_____Date_____

Medication List

Name of Medication	Strength	Directions (i.e. 1 per day, 2 every 6 hours)

Have you recently taken any over the counter medications or anti-inflammatory such as Advil, Motrin, Aleve, Celebrex, Vioxx, Ibuprofen, Naprosyn, Bextra, etc.?

If yes, please list medications:

Anti-Inflammatory Medications Recently Taken

Over The Counter Medications Recently Taken

Medication allergies:

_____

_____

Health History

Have you ever had the following? Please circle "Yes" for all applicable conditions.

Anemia	Yes	No	Hyperlipidemia	Yes	No
Arthritis	Yes	No	Hyperparathyroidism	Yes	No
Asthma/COPD	Yes	No	Hypertension	Yes	No
Atrial Fibrillation(AFIB)	Yes	No	Kidney Cyst	Yes	No
Congestive Heart Failure(CHF)	Yes	No	Kidney Failure	Yes	No
Cancer	Yes	No	Kidney Stones	Yes	No
Cancer within Last 5 Years	Yes	No	Lupus	Yes	No
Coronary Artery Disease	Yes	No	Polycystic Kidney Disease	Yes	No
Diabetes Type 1	Yes	No	Protein in Urine - Proteinuria	Yes	No
Diabetes Type 2	Yes	No	Recurrent Urinary Tract Infections	Yes	No
Blood in Urine - Hematuria	Yes	No	Stroke	Yes	No
Hepatitis A	Yes	No	Thyroid Disorder	Yes	No
Hepatitis B	Yes	No	Transplant	Yes	No
Hepatitis C	Yes	No	Vitamin D Deficiency	Yes	No

Other:

_____

Previous Hospitalizations and Surgeries (Please include dates):

_____

_____

Family Medical History

Please circle "Yes" and list relevant information for all applicable conditions.

Kidney disease	Yes	No	If yes, list family member(s):
Protein in urine	Yes	No	If yes, list family member(s):
Blood in urine	Yes	No	If yes, list family member(s):
Dialysis	Yes	No	If yes, list family member(s):
Diabetes Type 1	Yes	No	If yes, list family member(s):
Diabetes Type 2	Yes	No	If yes, list family member(s):
Hypertension	Yes	No	If yes, list family member(s):
SLE	Yes	No	If yes, list family member(s):
Kidney Stones	Yes	No	If yes, list family member(s):
Polycystic Kidney Disease	Yes	No	If yes, list family member(s):
Cancer	Yes	No	If yes, list family member(s):
Deafness	Yes	No	If yes, list family member(s):

Current Social History

Alcohol Intake	None	Occasional (≤1 drink per day)	Moderate (2 or less drinks per day)	Heavy (>4 drinks per day)	Other: ———				
Chewing Tobacco (times/ serving)	None	1 serving per day	2-4 servings per day	5+ servings per day	Other: ———				
Tobacco - years of use									
Smoking Status	Never Smoker	Former Smoker	Current every day smoker	Current some day smoker	Smoker - current status unknown	Unknown if ever smoked			
Smoking - How much?	None	<1 Pack Per Week	2 Packs Per Week	1/4 Pack Per Day	1/2 Pack Per Day	1 Pack Per Day	1 1/2 Packs Per Day	2 Packs Per Day	3+ Packs Per Day
Vaping Status	Never Vaped	Former Vaper	Current every day vaper	Current some day vaper	Vaper - current status unknown	Unknown if ever vaped			
Has smoked/ vaped since age?									
Use of Illicit Drugs									
Marital Status	Unknown	Married	Single	Divorced	Separated	Widowed	Domestic Partner		
Occupation									

Review of Systems

Please circle and describe how you are feeling today.

Constitutional	Fever	Fatigue	Weight gain (_____lbs)	Weight loss (_____lbs)		
Eyes	Dry Eyes	Vision Changes				
Mouth Throat	Sore throat	Snoring	Dry mouth			
Cardiovascular	Chest pain on exertion	Shortness of breath when walking	Palpitations	Known heart murmur	Light-headed on standing	Swelling in the extremities
Respiratory	Cough	Wheezing	Shortness of breath	Asthma	Sleep Apnea	
Gastrointestinal	Abdominal pain	Vomiting	Change in appetite	Diarrhea	Nausea	
Genitourinary	Urinary loss of control	Difficulty urinating	Increased urinary frequency	Blood in urine		
Musculoskeletal	Muscle aches	Arthralgias/joint pain	Back pain			
Skin	Jaundice	Rash	Itching			
Psychiatric	Depression	Restless Sleep				
Endocrine	Increased thirst	Heat intolerance	Cold intolerance			
Hematologic/ Lymphatic	Swollen glands	Easy bruising	Excessive bleeding			
Allergy/ Immunologic	Runny nose	Itching	Hives			

Consent for Treatment

I, _____, do hereby voluntarily consent to treat with _____. Treatment may include, but is not limited to, diagnostic, medical, or surgical treatment; labs/laboratory testing; injections; or other services. Treatment will be performed by the physicians of _____, and their assistants, advanced practice nurses, or other designees. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. _____ sometimes has medical students and/or medical residents in the clinic for teaching purposes. Any care provided by a medical student or resident will be under the supervision of a licensed physician employed by the practice.

I also acknowledge that the practice of medicine is not an exact science and treatment does not guarantee the condition will be resolved.

Consent for Telemedicine

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients from a virtual location.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. My consent will be obtained for anyone other than my healthcare provider to be present in the room.
3. I understand that there are potential downsides to using technology, including service interruptions, interception, and technical difficulties. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements.
4. I understand that I have the right to stop participating in a telemedicine visit, and that my decision will be documented in my medical record. I also understand that my decision will not affect my right to future care or treatment.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
    a. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    b. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
6. I understand that this document will become a part of my medical record. By signing this form, I agree that I (1) have personally read this form (or had it explained to me) and fully understand and consent to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of _____ _____and will be in _____ during my telemedicine visit(s).

I have read the above and hereby consent to treatment. Please initial next to each consent and sign.

_____ Consent to treat

_____ Consent to telemedicine

Patient Signature _____ Date _____

Consent for Ambient Notes

_____[PRACTICE NAME] may use a technology called ambient notes, which helps providers create clinical documentation. This technology is meant to increase the efficiency of documentation so that your doctor can spend more time providing care to patients. We are using new capabilities that are available in our existing electronic medical record system to do this. In order to use the ambient notes, a recording will be made of your visit with your doctor. Once the recording is made, the system generates clinical documentation that your doctor will review, can edit, and must be approved before it is added to your medical record. If you do not wish to use this technology, you must notify the practice staff so that we can update your chart with your preference.

Patient Signature _____ Date _____

Consent for Release of Information and Test Results

I, ______________________, give my consent and authorization to the staff of ____________________________ to relay medical information to the following person.

Contact Name:	Phone Number:	Relationship to Patient:	Authorization Start Date:
________________________	________________________	________________________	________________________

I give permission to share the following information (check all that apply):

- ☐ All Information
- ☐ Scheduling/Appointment Information
- ☐ Lab/Test Results, including Genetic Tests
- ☐ Billing and Payment Information
- ☐ Substance Use Disorder (drugs and/or alcohol)
- ☐ Medical Information (symptoms, diagnosis, medications, care plans)
- ☐ Behavioral/Mental Health Information (symptoms, diagnosis, medications, care
- ☐ plans) HIV/Aids and other Communicable Diseases (HBV, TB, etc.)
- ☐ Other, please describe: ______________________________________

I, ______________________, give my consent and authorization to the staff of ____________________________ to relay medical information to the following person.

Contact Name:	Phone Number:	Relationship to Patient:	Authorization Start Date:
________________________	________________________	________________________	________________________

I give permission to share the following information (check all that apply):

- ☐ All Information
- ☐ Scheduling/Appointment Information
- ☐ Lab/Test Results, including Genetic Tests
- ☐ Billing and Payment Information
- ☐ Substance Use Disorder (drugs and/or alcohol)
- ☐ Medical Information (symptoms, diagnosis, medications, care plans)
- ☐ Behavioral/Mental Health Information (symptoms, diagnosis, medications, care
- ☐ plans) HIV/Aids and other Communicable Diseases (HBV, TB, etc.)
- ☐ Other, please describe: ______________________________________

I, ______________________, give my consent and authorization to the staff of ____________________________ to relay medical information to the following person.

Contact Name:	Phone Number:	Relationship to Patient:	Authorization Start Date:
________________________	________________________	________________________	________________________

I give permission to share the following information (check all that apply):

- ☐ All Information
- ☐ Scheduling/Appointment Information
- ☐ Lab/Test Results, including Genetic Tests
- ☐ Billing and Payment Information
- ☐ Substance Use Disorder (drugs and/or alcohol)
- ☐ Medical Information (symptoms, diagnosis, medications, care plans)
- ☐ Behavioral/Mental Health Information (symptoms, diagnosis, medications, care
- ☐ plans) HIV/Aids and other Communicable Diseases (HBV, TB, etc.)
- ☐ Other, please describe: ______________________________________

Consent for Release of Information and Test Results Continued

I give _____ permission to leave voicemail or faxes with the following information:

☐

Appointments/Reminders

☐ Lab Orders/Results

☐ Payments

YES	NO	Location	Number
☐	☐	Home Phone	_____
☐	☐	Mobile Phone	_____
☐	☐	Fax Machine	_____

If the person or entity that you are authorizing to receive the information is not a health care provider or health plan covered by federal privacy regulations, the information provided to them may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. You may revoke this authorization at any time, provided to you do so in writing or by calling (480) 610-6100, except to the extent that action has been taken in reliance upon this authorization.

Patient Signature _____ Date _____

Financial Policy

Welcome to _____. We are dedicated to quality healthcare. We have experienced staff that understands your need for confidentiality and compassion. We are required to have you provide information to our office in order to file your insurance. Please be sure you have given us the correct insurance card as we will need to copy both front and back of the card. We also will ask that you provide us with a picture ID for your chart (i.e. driver's license, etc.). Co-payments are due at the time of service. We ask that any balance owing be paid promptly.

Please read and sign the following so that we may file your insurance.

I, _____ authorize _____ to release information regarding my health to my insurance company. I understand that my insurance company may request records from my physician in order to pay the claims submitted. I give permission to _____ to send any records necessary to obtain payment for the claims submitted. I assign all insurance benefits to _____. I understand that I am fully responsible for any/and all unpaid charges and agree to pay any balance unpaid by my insurance company. This authorization will remain in effect from this date until revoked by me in writing.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Good Faith Estimate

You have a right to receive a “Good Faith Estimate” explaining how much your medical care will cost. Under the law, healthcare providers need to give patients who do not have insurance or are not using insurance an estimate of the bill for medical items and services. You also have the right to receive an estimate for the total expected cost of non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

Make sure your healthcare provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service. You can also ask your healthcare provider for a Good Faith Estimate before you schedule an item or service.

If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call (800)

985-3059. Patient Signature _____ Date _____

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is a way for providers to send electronically, an accurate, error-free, and understandable prescription from the provider's office to the pharmacy. This program also includes:

Medication History Transactions: provides the healthcare provider with information about your current and past prescriptions. This allows your providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate compliance with prescribed regimens, therapeutic interventions, drug-drug and drug-allergy reactions, adverse drug reactions, and duplicative therapy.

The medication history information would include medications prescribed by your healthcare provider at _____ as well as other healthcare providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic disease, and HIV/AIDS. As part of this consent form, you specifically consent to the release of this and other sensitive health information.

Consent

By signing this consent form, you are agreeing that your provider at _____ may request and use your prescription medication history from other healthcare providers and/or third party benefit payors for treatment purposes. You may decide not to sign this form. Your choice will not affect your ability to receive medical care, payment for your medical care, or your medical care benefits. You also have the right to receive a copy of this form after you have signed it. This consent form will remain in effect until the day you revoke your consent. You may revoke your consent at any time in writing. Please note, this revocation will not have an effect on any actions taken prior to receipt of the revocation.

Understanding all of the above, I hereby provide informed consent to _____ to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name: _____

Name/Relationship (If signed by individual other than patient) _____ Date _____

Patient Signature _____ Date _____

Witness Signature _____ Date _____

CONTACT FOR FUTURE RESEARCH

Why would I be contacted? We frequently partner with organizations to participate in various research projects and clinical trials ("Study or Studies"). These Studies may lead to better treatments for the types of medical problems experienced by the patients of this practice. The practice, or its partners, may contact you in accordance with applicable laws to see if you want to learn more about their Studies or if you may wish to participate in any of the Studies that may be appropriate for you. You have no obligation to participate in any Study.

Are there any financial considerations? There will be no cost or payment to you if you decide to participate in future Studies.

If you have any questions or wish to change your preferences, please call (866) 886-5007 or email privacy@panoramichealth.com

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.

Effective date: _____ Revised: _____

INTRODUCTION

This is a notice by _____. The practice is affiliated with a Management Services Organization (USN OPCO LLC. dba Panoramic Health and subsidiaries). This relationship allows the Practice to delegate certain operational functions to these entities. These operational functions may include quality improvement, risk management, financial and billing services, health information exchanges, and clinical research management.

You understand and acknowledge that the Practice will disclose information in accordance with HIPAA laws to our delegated entities (namely, Panoramic Science, LLC and RCO Analytics, LLC) for the purposes of creating a population health care delivery model with goals of improving quality of health care and outcomes, reducing costs of health care, and increasing savings to patients.

This notice uses the words "protected health information (PHI)" or "health information." Those words are defined in the HIPAA regulations. In simple terms, your "protected health information" is information about you and your healthcare that we use and disclose for your treatment and payment for your care, and for our healthcare operational purposes. It includes basic identifying information like your name, address, age, race, phone number, as well as information in your medical records and billing records. PHI can be oral, or in paper or electronic formats.

WHO MUST FOLLOW THIS NOTICE?

We provide you, the patient, with health care by working with doctors and many other health care providers (referred to as we, our, or us). This is a notice of our information privacy practices. The following people or groups will follow this notice:

- All Practice employees.
- Any health care provider who comes to our locations to care for you. These professionals include doctors, nurses, technicians, physician assistants, and others.
- All departments and units of our organization.
- Offices and affiliates performing duties for the Practice.

OUR PLEDGE TO YOU

We understand that your protected health information is private and personal. We are committed to protecting it. Practice employees and other staff members make a record each time you visit. This notice applies to all the records of your care at the Practice, whether created by staff members or your doctor. We will gladly explain this notice to you or your family member.

We are required by law to:

- Keep your protected health information private.
- Give you this notice describing our legal duties and privacy practices for your protected health information.
- Notify you as outlined in state and federal law if a breach of your unsecured protected health information has occurred. • Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND SHARE YOUR PROTECTED HEALTH INFORMATION

This section of our notice tells how we may use and share your protected health information, including sharing electronically. In situations not covered by this notice or otherwise allowed by law and regulation, we will get a separate written permission from you before we use or share your protected health information. You can later cancel your permission by notifying us in writing. We will protect your protected health information as much as we can under the law. Sometimes state law gives more protection to your information than federal law. Sometimes federal law gives more protection than state law. In certain instances, we may deidentify your data and share it with third parties for the purpose of advancing knowledge about certain conditions. If you do not wish to have your information shared for this purpose, please notify us in writing. In each case, we will apply the laws that protect your information the most.

Treatment: We will use and share your protected health information, both internally and externally, to provide you with health care treatment and to coordinate or manage your treatment with other health care providers. An example is sending medical information about you to another specialist as part of a referral. We may also share your information with other types of health care providers after you leave our Practice, such as pharmacies, home health agencies, specialty hospitals, or long-term care facilities.

Payment: We will use and share your protected health information so we can be paid for treating you. An example is giving information about you to your health plan or to Medicare. We may also need to give information to your health plan to get approval for certain services or to find out if your plan will pay for certain treatment. We may also share your health information with other health care providers involved in your healthcare, such as your personal physician, anesthesiologist, ambulance services, so that they may receive payment for their services. We may also give your healthcare information to individuals who are responsible for payment for your health care, such as the named insured on your health insurance policy. For example, the person named may receive a copy of an explanation of benefits (EOB) related to your care.

Health Care Operations: We will use and share your medical information for our health care operations. A few examples are using information about you for:

- Improving the quality of care we give you.
- Disease management, wellness management, or population health programs.
- Patient surveys.
- Training students.
- Business planning and administration.
- Resolving patient complaints.
- Getting or keeping our accreditation.
- Compliance and legal services.
- For participation in Clinical Research studies.

We may also share your protected health information with people or companies (called business associates) we use to help us with our operations.

Family Members, Personal Representatives, and Others Involved in Your Care: Unless you tell us otherwise, we may share your protected health information with your friends, family members, or others you have named who help with your care or who can make decisions on your behalf about your health care. Also, if you cannot agree due to an emergency, we may share needed protected health information about you with your family or friends who are involved in your care, based on professional judgment of what is in your best interest. In rare instances, even without your permission, we may share your information with others if the physician or health care provider feels it is in your best interest.

Electronic Sharing and Pooling of Your Information: We may take part in or make possible the electronic sharing or pooling of healthcare information. The most common way we do this is through local or regional health information exchanges (HIEs). Two other types of HIEs we participate in are described in the next two sections. HIEs help doctors, hospitals and other healthcare providers within a geographic area or community provide quality care to you. If you travel and need medical treatment, HIEs allow other doctors or hospitals to electronically contact us about you. All of this helps us manage your care when more than one doctor is involved. It also helps us to keep your health bills lower (avoid repeating lab tests). And finally, it helps us to improve the overall quality of care provided to you and others. We are involved in national health reform efforts and may use and share information as permitted to achieve regional or national goals, including regional or nationally approved population health management or wellness initiatives.

State-Based Health Information Exchange: These facilities may participate in statewide internet-based HIE. As permitted by law, your health information will be shared through the HIE to provide faster access, better coordination of care and to assist healthcare providers, health plans, and public health officials in making more informed decisions. To opt in or out of the HIE, you must notify the HIE yourself.

Research: We may use and share your protected health information for research projects, such as studying the effectiveness of a treatment you received. We will usually get your written permission to use or share your information for research. Under certain circumstances, we may share your protected health information without your written permission. These research projects, however, will be approved by a special committee that protects the confidentiality of your medical information.

Substance Use: Substance Use and Substance Use Disorder records are treated like any other protected health information. They may be used or disclosed in accordance with HIPAA regulations. However, Substance Use records may not be used or disclosed to initiate or substantiate criminal, civil, or administrative actions against a patient. Patients have the right to request restrictions on uses and disclosures, revoke consent (with limits), receive an accounting of disclosures, including for treatment, payment, and healthcare operations. Patients may file a complaint with the practice or the Office for Civil Rights (OCR). Substance use records may be used and disclosed for treatment, payment, and healthcare operations purposes.

Appointment Reminders: We may contact you by phone, email, or text messaging with appointment reminders.

Internet Based Products and Services: Working with third parties, we may share your health information so we can offer you internet-based products or services. Using the products or services, you can:

- Schedule appointments.
- Reduce wait times in our emergency rooms.
- Find a physician or get access to your medical information through a portal.

Treatment Options and Health-Related Benefits and Services: We may contact you about possible treatment options, health-related benefits, or services that we offer. Health Education and Health Programs: We may send you newsletters or brochures or contact you about health-related information, disease management programs, wellness programs, or other local programs that you might want.

INFORMATION SHARING THAT IS REQUIRED OR PERMITTED BY LAW

We are required or permitted by federal, state, or local law to report or share your health information for various purposes. Some of these required or permitted purposes are:

Public Health Activities: We may share your protected health information as required or permitted by law to public health authorities or government agencies whose official activities include preventing or controlling disease, injury, or disability. For example, we must report certain information about births, deaths, and various diseases to government agencies. We may use your health information in order to report to monitoring agencies any reactions to medications or problems with medical devices. We may also share, when requested, your protected health information with public health agencies that track opioid usage, contagious diseases, or that are involved with preventing epidemics.

Required by Law: We are sometimes required by law to report certain information. For example, we must report child and elder abuse and neglect, and in some states, spouse abuse or neglect. We are required to report certain types of injuries, such as injuries caused by firearms. We also must give information to your employer about work-related illness, injury, or workplace-related medical surveillance. Another example is that we must share information about tumors with state tumor registries.

Public Safety: We may, and sometimes must, share your health information in order to prevent or lessen a serious threat to you or to the health or safety of a particular person or the general public.

Health Oversight Activities: We may share your health information with a health oversight agency when allowed by law for health oversight activities. Health oversight agencies include the agencies that run Medicare and Medicaid, and state medical or nursing licensing boards. Health oversight activities include audits, investigations, or inspections. The activities are necessary so the government can monitor health care treatment and spending, government programs, and also compliance with civil rights laws.

Coroners, Medical Examiners and Funeral Directors: We may share health information about deceased patients with coroners, medical examiners, and funeral directors to identify a deceased person, determine the cause of death, or other duties as permitted.

Military, Veterans, National Security and Other Government Agencies: We may use or share your health information for national security purposes, intelligence activities, or for protective services for the President or certain other persons as allowed by law. We may share your health information with the military for military command purposes when you are a member of the armed forces. We may share medical information with the Secretary of the Department of Health and Human Services for investigating or determining our compliance with HIPAA.

Judicial or Administrative Proceedings: We may use or share your health information in response to court orders or subpoenas only when we have followed procedures required by law.

Law Enforcement: We may share your health information if law enforcement officials ask us to or if we have a legal obligation to notify the appropriate law enforcement or other agencies:

- In response to a court order, subpoena, warrant, summons or similar legal process. • Regarding a victim or death of a victim of a crime in limited circumstances.
- In emergency circumstances to report a crime, the location or victims of a crime, or the identity, description or location of a person who is alleged to have committed a crime, including crimes that may occur at our facility, such as theft, drug diversion, or attempts to obtain drugs illegally.

Disaster Relief Purposes: We may use or share your health information with public or private disaster organizations, like the American Red Cross, so that your family can be told of your location and condition in case of disaster or emergency. We may also use it to help in coordination of disaster relief efforts.

Workers' Compensation: We may share your health information for workers' compensation benefits or similar programs that provide benefits for work-related injuries or illnesses if you tell us that workers' compensation is the payer for your visit(s). Your employer or workers' compensation carrier may request the entire medical record for your workers' compensation claim. This medical record may include details regarding your health history, current medications you are taking, and treatments.

Inmates: If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may share your health information with the institution or law enforcement official. We may do this for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

OTHER USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Apart from what we say in this Notice, we will not use or share your health information unless we get your written permission. Under HIPAA, this permission is called an "authorization." If you give us written permission to use or disclose your health information, you may revoke (take back) that permission in writing at any time. If you revoke your permission, we will no longer use or disclose your health information for the purpose involved. However, we cannot retrieve any disclosures that we already made based on your prior permission.

We will get your written permission to use and disclose your health information for these specific purposes when required by law:

Marketing:
Marketing means to make a communication about a product or service that you may be interested in buying. If we send a marketing communication to you about a service or product unrelated to the Practice, or if we receive payment from a third party in order for us to promote a product or service to you, then we are required to get your written permission before we can use or disclose your health information.

We are not required to get your written permission to talk with you in person or send you information about the following:

- Health care treatment options.
- Health-related products and services that are provided by the Practice. • Case management or care coordination services.
- Recommended alternative treatments, therapies, providers, or settings of care. • Samples or promotional gifts of nominal value.

You have the right to revoke (take back) your marketing permission and we will honor the revocation. To find out who to contact for opting out of these communications, please contact the Privacy Officer.

Sensitive Medical Information: We may obtain a written permission from you, when required by state and federal laws, to use or share sensitive medical information, such as mental health, substance abuse, or genetic testing information.

Sale of Health Information:
We will obtain your authorization for any disclosure of your identifiable health information if we directly or indirectly receive remuneration (money or other valuable things) in exchange for the health information.

THIS NOTICE DOES NOT APPLY TO THE FOLLOWING HEALTH RELATED ACTIVITIES

Some activities may not be covered by this notice and are referred to as Hybrid activities under HIPAA. If you participate in research activities conducted by academic institutions after your information has been legitimately sent to them, or obtain direct access lab services, this notice and HIPAA do not apply.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Your rights are listed below. Some of the rights require a written request form. You can get the appropriate written request form from the departments outlined below.

Requesting Your Information (Access or Copy): In most cases, when you ask in writing, you can look at or get a copy of your protected health information in your medical records or applicable parts of your billing record in paper or electronic format. You may also request that we send electronic copies directly to a person or entity chosen by you. We will give you a form to fill out to make the request. You can look at medical information about you for free. If you request paper or electronic copies of the information, we may charge a fee to cover the cost of copying, mailing, and supplies. To request a copy of your information, contact the Practice Manager.
If we say no to your request to look at the information or get a copy of it, we will tell you why in writing. Also, you may ask us in writing to review that decision. A health care professional will review your request and the decision. The person who makes the review will not be the same person who said no to your request. We will follow the outcome of the review.

Correcting Your Information (Amendment): If you believe that information about you is wrong or not complete, you can ask us in writing to correct the records (make an amendment). We will give you a form to fill out to make the request. We may say no to your request to correct a record if the information was not created or kept by us or if we believe the record is complete and correct. If we say no to your request, you can ask us in writing to review that denial.

Obtaining a List of Certain Disclosures (Accounting of Disclosures): You can ask to receive a list of certain disclosures we have made of your protected health information during the last six years. To get the list, ask for the Accounting of Disclosures Form from the Practice Manager or the Privacy Officer. Your request must be in writing and state the time period (up to six years) for the listing. The first request in a 12-month period is free. We will charge you for any additional requests for our cost of producing the list. We will give you an estimate of the cost when you request the additional list.

Right to Ask for Confidential Communications: You have the right to ask us to communicate with you about health care matters in a certain way or at a certain address. For example, you can ask that we only contact you at a different location from your home address, such as work, or only contact you by mail instead of by phone. Your request must tell how or where you want to be contacted. We do not require a reason. We will agree to all reasonable requests.

Right to Ask for a Restriction: You can ask in writing that we limit our use or sharing of your protected health information for treatment, payment, and operational purposes. We are not required to agree to most requests. Any time you make a written request, we will consider the request and tell you in writing of our decision to accept or deny your request. We are legally required to agree to only one type of restriction request: if you have paid us in full for a health procedure or item for which we would normally bill your health plan, we must agree to your request not to share information about that procedure or item with your health plan. For example, if you saw a counselor and paid in full for the services rather than submitting the expenses to your health plan, you may ask that your health information related to the counseling not be shared with your health plan.

Right to Receive Notice of a Privacy Breach: We will tell you if we discover a breach of your health information. Breach means that your health information was disclosed or shared in an unintended way and there is more than a low probability that it has been compromised. The notice will tell you about the breach, about steps we have taken to lessen any possible harm from the breach, and actions that you may need to take in response to the breach.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. If you have received this notice electronically, you still can have a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

To ask questions about any of these rights, or to obtain a paper copy of this notice, contact the Privacy Officer. You may also obtain a copy of this notice at our website.

CHANGES TO THIS NOTICE

We may change our privacy practices from time to time. Changes will apply to current medical information, as well as new information after the change occurs. If we make an important change, we will change this notice. We will also post the new notice in our facilities and on our website. You can ask in writing for a copy of this notice at any time by contacting the facility's Practice Manager or Privacy Officer. If our notice has materially changed, we will give you a copy of the notice the next time you register for treatment.

DO YOU HAVE CONCERNS OR COMPLAINTS?

If you think your privacy rights may have been violated, you may contact us at privacy@panoramichealth.com or call 1-866-886-5007, or contact the facility's Privacy Officer. You may also send a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights at OCRComplaint@hhs.gov or Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201. We will not take any action against you or change our treatment of you for filing a complaint.

CONTACT INFORMATION

privacy@panoramichealth.com

(866) 886-5007

Acknowledgement of Receipt of
Notice of Privacy Practices

I acknowledge that I have received a copy of this office's Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed and protected.

Patient Name:

Name/Relationship (If signed by individual other than patient) _____ Date _____

Patient Signature _____ Date _____

Witness Signature _____ Date _____