

Jacksonville	Jack Southv	vest Jack	Western Jac	k Marine Blvd. (PIC)	Richlar
Emerald Isle	Sneads Fe	erry South	nport Clint	on Swansboro	Dillon
Kenansville (CC	СРМ) М	ount Airy	New Bern	Carolina Beach	Statesvil

Mount Airy

MMEDIATE

PATIENT INFORMATION SHEET

Carolina Beach

Statesville

Account #	Nan	ne of Employer	r:		
First Name:	Mic	ddle Initial	Last Name: _		
Mailing Address:		Apt./Suite	City	State	Zip
Home Phone:	Work Number	:	Cell Phone	Number:	
Email Address:		En	nployer		Sex
Marital Status:	Birth Date:	//	SSN:	/ /	
Ethnicity: (check one) Hispan	ic or Latino	Not Hispanic	or Latino	_ Declines to Respond	l Race:
(check one) American Indian	/ Alaskan Native_	Asian_	Black/Afr	rican American	
Native Hawaiian Other l	Pacific Islander	White	More than 1 Rad	ce Declines to Res	spond
Preferred Language:		Prefer	red Provider		
	You may need	to fill out add	litional informat	tion	
Emergency Contact:	•				
			•		
If Patient is a minor:					
Guarantor Name:		Add1	ress:		
City:		Sta	te: Zip:		
Phone:1	Name of Employer	:		Cell Phone:	
To Pı	rocess your Insura	nce Claim, yo	u must complete	e this section	
Health Insurance Information		•	•		
Name of Insurance:					
Policy Number:					
Policy Holder / Sponsor Name		_			
Policy Holder / Sponsor Date					
Policy Holder / Sponsor Socia		•	- '		
Policy Holder / Sponsor relation					
Do you have your insurance ca					
· •	<u> </u>				
Assignment of Benefits:					

I hereby authorize Med First to examine me, including x-ray and procedures deemed appropriate by the treating provider if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my medical records to be held in strict secret confidence and not to be given to anyone without my written consent. I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by Med First Immediate Care. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal Law.

	/ /
Patient / Representative Signature	Date

FAMILY PRACTICE HEALTH HISTORY QUESTIONAIRE

Your Answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any questions, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THE QUESTIONAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTAL.

Patient Name:			Date of birth:	
Main Reason for t	oday's visit: _			
ALLERGIES				
List anything that y	you are allergi	c to (medication, food, bee stir	ngs, etc.) and how each affects you.	
Allergy			Reaction	
1				
2				
3				
FAVORITE PHARM	ACY			
MEDICATIONS				
	nedications yo	u are taking. Include prescribe	d drugs and over-the-counter drugs, such as	vitamins and inhalers.
DRUG NAME		STRENGTH		NCY TAKEN
1		1	1	
2				
3				
4				
5				
IMMUNIZATION H O Chickenpox	ISTORY (or pro	ovide list) Date:	O Meningococcus	Date:
O Flu Shot		Date:		Date:
O Gardisil/HPV		Date:		
O Hepatitis A		Date:		Date:
O Hepatitis B		Date:	O Tdap (Tetanus and Pertussis)	Date:
o riepatitis b			O Tetanus	
			O Zostavax (Shingles)	Date:
				Date:
OBSTETRIC AND G	YNECOLOGICA	AL HISTORY		
Last Pap Smear	Date:	Abnormal	Sexually active Current sexual	partner is: O female O male
Last Mammogram	Date:	Abnormal	Do you use condoms? O Yes	O No
Age of first menstr	ual period:		Interested in being screened for STD	'S: O Yes O No
Age at first child:			Check all that apply:	
Date of last menstr	ual period or	age of menopause:	O Bleeding between periods	O Extreme menstrual pain
Number of pregnar	ncies: bir	ths:	O Heavy periods	O Painful intercourse
miscarriages:		abortions:	O Vaginal itching burning or disch	narge
Cesarean sections	If yes, then	number:	O Wake in the night to go to the	
			O Breast lump or nipple discharge	
			O Hot flashes	
			Other Birth control method used	

PAST MEDICAL HISTORY

Please check	all that apply:								
O Anxiety Dis	order	0.0	Diverticulit	tis		() Kidney Di	sease	
O Arthritis		O Fibromyalgia				O Kidney Stones			
O Asthma			out			O Leg/Foot Ulcers			
O Bleeding Di	sorder	OH	las Pacem	aker			Liver Dise		
O Blood Clots			leart Attac				Osteopor		
O Cancer	î.	OH	leart Disea	ase				y Embolism	
O Coronary Ar	tery Disease	OH	liatal Hern	nia or Re	eflux Disease		Reflux or		
O Diabetes- N			IIV or AIDS		ax Discuse) Stroke	Oicers	
O Diabetes- In	sulin		igh Blood		re	O Stroke O Tuberculosis			
O Dialysis			veractive			O Other			
			PAST SU	JRGICA	L HISTORY				
SURGERY		REASON			YEAR			IOSPITAL	
1					TEAN		,	IOSPITAL	
2							-, · · · · ·		
3							-		
4									
			FAMILY	HEALTH	HISTORY				
	Maternal	Maternal	Pater	rnal	Paternal				
	Grandmother	Grandfather	Grandm		Grandfather	Father	Mother	Brother	Sister
Heart disease									
Cancer									
Diabetes									
Stroke		· · · · · · · · · · · · · · · · · · ·							- TE
Hypertension									
Depression									
Osteoporosis									
Other (please									
specify)									
			SOCIAL I	HISTOR	<u>Y</u>				
Current Occupa	ation	Diet		O.D.		_			
current occupa	ition	Diet		O Reg		10	bacco Do	you use tob	
Education ()	Less than 8 th grade				getarian	10		O Yes O	
O High School (O Veg				ly, did you e	ver use
	O Post graduate				O Gluten Free O Diabetic		bacco? O Y		
O 4 year conege	. O i ost graduate			O Dia	betic			Pks/day	
Marital Status O Married O Single		Caffeine O N		O No				hew/day	
O Divorced O Separated		Carre	ille		casional		O Cigars/day of year's or year quit		
	Domestic partner				derate	# 0	or year s	or year qu	uit
o widowed o	bomestic partiter			O Hea		D			
Do you have ad	vanced directives?			Опес	avy			ou currently	
Do you have advanced directives? O Yes O No		Alcoh	nol	0.000	O Occasionally		ecreational or street drugs? O Yes O No		gs r
2 100 0 110		Aicoi	.01		times a week	1.5		ONO	
Exercise Level	O None				times a week		es,		
	O Occasional	Stron	s Level		v O Medium	IIST	•		
	O Moderate	31165	Level			(
	o moderate			O Hig	П				

O High level

Current Symptoms

Ple	ease check all that apply	Ea	rs/Nose/Mouth/Throat		Genitourinary		Neurological		
,	Allergic/Immunologic	0	Bleeding gums	0	Blood in Urine	0	Dizziness		
		0	Difficulty hearing	0	Difficulty Urinating	0	Fainting		
O	Frequent sneezing	0	Dizziness	0	Incomplete Emptying	О	Headache		
O	Hives	0	Dry Mouth	0	Increased Urinary	0	Memory Loss		
O	Itching	0	Ear pain		Frequency	0	Migraines		
O	Runny nose	0	Frequent infections	0	Urinary Loss of Control	0	Numbness		
O	Sinus Pressure	0	Frequent nosebleeds			0	Restless Leg		
		0	Hoarseness	Н	ematologic/Lymphatic	0	Seizures		
	Cardiovascular	0	Mouth breathing			0	Weakness		
		0	Mouth ulcers	0	Easy Bruising/Bleeding				
O	Arm pain on	0	Nose/sinus problems	0	Swollen Glands		Psychiatric		
	extension	0	Ringing in Ears						
O	Chest pain on				Integumentary (skin)	0	Alcohol overuse		
	exertion					0	Anxiety/Stress		
O	Chest		Endocrine	О	Changes in Moles	0	Depression		
	heaviness/pressure			0	Dry Skin	0	Do not feel safe in		
	on exertion	0	Fatigue	0	Eczema		relationship		
O	Irregular Heart Beats	0	Increase	0	Growth/Lesions	0	Mania		
O	Known Heart Murmur		Thirst/Hunger/Urination	0	Itching	0	Sleep Problems		
O	Light-headed on		, 0 ,	0	Jaundice (yellow		orecp repression		
	Standing				skin/eyes)		Respiratory		
O	Shortness of Breath		Gastrointestinal	0	Rash		y		
	when walking					0	Cough		
O	Swelling (edema)	0	Abdominal pain		Musculoskeletal	o	Coughing up Blood		
		0	Black or Tarry Stool			o	Shortness of Breath		
	Constitutional	0	Blood in Stool	0	Back Pain	o	Sleep Apnea		
		0	Change in Appetite	0	Joint Pain	o	Snoring		
O	Exercise intolerance	O	Frequent Indigestion	O	Muscle Aches	o	Wheezing		
O	Fatigue	O	Hemorrhoids	0	Muscle Weakness	U	Wileezing		
O	Fever	0	Trouble Swallowing						
O	Weight Gain (lbs)	0	Vomiting						
Ο	Weight Loss (lbs)	0	Vomiting Blood						
	Eyes								
О	Dry eyes								
O	Irritation								
Ο	Vision Change								
	Date of Last	1							
	Exam:								
	Please add any other info	rmation	about your health that you	would	like your provider to know	here:			
	Patient/Guardian				Data				

Guardian relationship to patient _____



PROMISSORY NOTE

Name	
Please choose your payment	source
Private Pay:	
I,	am acknowledging that I am a self paying at the time of service or pay my balance in full
Insurance:	
I,	naining balance (if any) in accordance with my
Workman's Compensation:	
I,	sponsible for the charges n the account. Such
Personal Injury:	
I,my attorney, private insurance and/or claim adjustor. I will be responsible f sources listed. Such payments will be paid within 30 days of receipt of sta with the information needed to process any and all claims.	
Signature of responsible party	
Data / /	



AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I. Patient's Name		DOB	
Phone Number	_		
If you want to allow others access to proceed to section V	o your personal health informatio	on please complete section	n II – IV otherwise
II. Please check one and provide the re	equested information:		
	e the Med First Immediate Care & F Information to the following organiz		s Medical Providers to
Name:			
Address:			
III. I authorize the following information			
Comple GYN (P Lab X-ray	ete Medical Record, including record ete Medical Record while at Med Fire Pap, Pelvic, Lab) or Relating to Particular Problem	st, not including records fror	n other providers
IV. Purpose of the Requested Disclosu	ure: Please check one and provide t	the requested information.	
At the request of the pa	atient.	(Patient's initials)_	
Other			
	(State specific purpose of requested d	isclosure)	
V. I understand that I have a right to revoke Manager or other health care provider ident that the persons I have authorized to use understand that I do not have to sign this payment, enrollment or eligibility for benefit authorized to receive the information is not longer be protected by federal privacy regulealth information which could contain dia diseases including but not limited to: alcoldisorders; and/or Sickle Cell.	tified in Section II above, as applicable. and/or disclose my Protected Health In authorization and that Med First Imme its on whether I sign this authorization. It a health plan or health care provider, tulations. I understand that the information gnosis and treatment information includes	I am aware that my revocation formation have acted in reliand diate Care & Family Practice relianter understand that if the particular that if the released information may be no provided under this authorized in ginformation pertaining to c	n is not effective to the extent ce upon this authorization. I may not condition treatment, persons(s) or organization(s) e re-disclosed and would no tation may include Protected hronic and/or communicable
Your provider and members of the practice with appointment reminders, information at contract is made by phone and your not hauthorization to contact you with these reminders.	bout treatment alternatives, or other hea nome, a message will be left on your a	alth related information that may	y be of interest to you. If this
I agree that a copy of this release or fax o Family Practice to fax the information, I real			Med First Immediate Care &
This authorization expires upon			
Signature of Patient or Patient's Repre	esentative	_	Date
Printed Name of Patient's Representat	tive	_	Relationship to patient

Med First Immediate Care and Family Practice, PA

NOTICE OF PRIVACY PRACTICE AND PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME	DATE
I understand that under Health Insurance Portability and Accountability Act of 1 Patient Rights regarding my protected health information.	996 (HIPAA), I have certair
I understand that Med First Immediate Care and Family Practice, PA may use or information for treatment, payment or health care operations-which means for propatient; handling billing and payment; and, taking care of other health care operations without my authorises will be no other uses and disclosures of this information without my authorically	oviding health care to me, the ions. Unless required by law
Med First Immediate Care and Family Practice, PA has a detailed document capractices. It contains a more complete description of your rights to privacy and haprotected health information.	
I understand that I have the right to read the 'Notice' before signing this agreement ate Care and Family Practice, PA will provide me with the most current Notice of	
My signature below indicates that I have been given the chance to review such or Practices. My signature means that I agree to allow Med First Immediate Care and disclose my protected health information to carry out treatment, payment, a have the right to revoke this consent in writing at any time, except to the extent the and Family Practice, PA has taken action relying on this consent.	nd Family Practice, PA to use and health care operations.
SIGNATURE (Patient or Legal Custodian/Authorized Representative)	DATE
Relationship to Patient if signed by another party	DATE

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting:

Med First Immediate Care and Family Practice, PA 308 Dolphin Drive Jacksonville, NC 28546 or call (910) 346-2273

Note this is a NPP that reflects Omnibus changes as of March 2013 Med First Immediate Care & Family Practice, PA

NOTICE OF PRIVACY PRACTICES - Effective Date: 09/23/13

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

If you have any questions about this Notice of Privacy Practices ('Notice'), please contact: Privacy Officer / Olivia Antwine · Phone Number: 910-346-2273

Section A: Who Will Follow This Notice?

This Notice describes Physicians Immediate Care, a division of Med First Immediate Care & Family Practice, PA (hereafter referred to as 'Provider') Privacy Practices and that of: Any workforce member authorized to create medical information referred to as Protected Health Information (PHI) which may be used for purposes such as Treatment, Payment and Healthcare Operations. *These workforce members may include:*

- · All departments and units of the Provider.
- · Any member of a volunteer group.
- · All employees, staff and other Provider personnel.
- Any entity providing services under the Provider's direction and control will follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for Treatment, Payment or Healthcare Operational purposes described in this Notice.

Section B: Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Provider. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or maintained by the Provider, whether made by Provider personnel or your personal doctor.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- · Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

Section C: How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

· Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other Provider personnel who are involved in taking care of you at the Provider. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the Provider also may share medical information about you in order to coordinate different items, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the Provider who may be involved in your medical care after you leave the Provider.

· Payment:

We may use and disclose medical information about you so that the treatment and services you receive at the Provider may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at the Provider so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a prescribed treatment to obtain prior approval or to determine whether your plan will cover the treatment.

· Healthcare Operations:

We may use and disclose medical information about you for Provider operations. These uses and disclosures are necessary to run the Provider and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Provider patients to decide what additional services the Provider should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health care students, and other Provider personnel for review and learning purposes. We may also combine the medical information we have with medical information of the Providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning a patient's identify.

Appointment Reminders:

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Provider.

· Treatment Alternatives:

We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

· Health-Related Benefits and Services:

We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

· Fundraising Activities:

We may use information about you to contact you in an effort to raise money for the Provider and its operations. We may disclose information to a foundation related to the Provider so that the foundation may contact you about raising money for the Provider. We only would release contact information, such as your name, address and phone number and the dates you received treatment or services at the Provider. If you do not want the Provider to contact you for fundraising efforts, you must notify us in writing and you will be given the opportunity to 'Opt-out' of these communications.

· Authorizations Required:

We will not use your protected health information for any purposes not specifically allowed by Federal or State laws or regulations without your written authorization, this includes uses of your PHI for marketing or sales activities.

Emergencies

We may use or disclose your medical information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.

· Psychotherapy Notes:

Psychotherapy notes are accorded strict protections under several laws and regulations. Therefore, we will disclosure psychotherapy notes only upon your written authorization with limited exceptions.

· Communication Barriers:

We may use and disclose your health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

· Provider Directory:

We may include certain limited information about you in the Provider directory while you are a patient at the Provider. This information may include your name, location in the Provider, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. This is so your family, friends and clergy can visit you in the Provider and generally know how you are doing.

· Individuals Involved in Your Care or Payment for Your Care:

We may release medical information about you to a friend or family member who is involved in your medical care and we may also give information to someone who helps pay for your care, unless you object in writing and ask us not to provide this information to specific individuals. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research

Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a re search project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Provider. We will almost always generally ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the Provider.

· As Required By Law:

We will disclose medical information about you when required to do so by federal, state or local law.

· To Avert a Serious Threat to Health or Safety:

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

· F-mail Use:

E-mail will only be used following this Organization's current policies and practices and with your permission. The use of secured, encrypted e-mail is encouraged.

Section D: Special Situations

· Organ and Tissue Donation:

If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

· Military and Veterans:

If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

· Workers' Compensation:

We may release medical information about you for workers' compensation or similar programs.

· Public Health Risks:

We may disclose medical information about you for public health activities. These activities generally include the following:

- · to prevent or control disease, injury or disability;
- · to report births and deaths:
- · to report child abuse or neglect;
- · to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

· Health Oversight Activities:

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes:

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

· Law Enforcement:

We may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- · about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- · about a death we believe may be the result of criminal conduct;
- · about criminal conduct at the Provider; and
- in emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

· Coroners, Medical Examiners and Funeral Directors:

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Provider to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities:

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

· Protective Services for the President and Others:

We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

· Inmates:

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary 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.

Section E: Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

· Right to Access, Inspect and Copy:

You have the right to access, inspect and copy the medical information that may be used to make decisions about your care, with a few exceptions. Usually, this includes medical and billing records, but may not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

· We may deny your request to inspect and copy medical information in certain very limited circumstances:

If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the Provider will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

· Right to Amend:

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Provider. In addition, you must provide a reason that supports your request.

- · We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Provider;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

· Right to an Accounting of Disclosures:

You have the right to request an 'Accounting of Disclosures'. This is a list of the disclosures we made of medical information about you. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the accounting (for example, on paper or electronically, if available). The first accounting you request within a 12 month period will be complimentary. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

· Right to Request Restrictions:

You have the right to request a restriction or limitation on the medical information we use or disclose about you for payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply (for example, disclosures to your spouse). We are not required to agree to these types of request. We will not comply with any requests to restrict use or access of your medical information for treatment purposes.

You also have the right to restrict use and disclosure of your medical information about a service or item for which you have paid out of pocket, for payment (i.e. health plans) and operational (but not treatment) purposes, if you have completely paid your bill for this item or service. We will not accept your request for this type of restriction until you have completely paid your bill (zero balance) for this item or service. We are not required to notify other healthcare providers of these restrictions, that is your responsibility.

Right to Receive Notice of a Breach:

We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

- a brief description of the breach, including the date of the breach and the date of its discovery, if known;
 a description of the type of Unsecured Protected Health Information involved in the breach;
- steps you should take to protect yourself from potential harm resulting from the breach;
- · a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
- contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional Information.

In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our website or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

Right to Request Confidential Communications:

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or hard copy or e-mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

· Right to a Paper Copy of This Notice:

You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our website. www.ThinkMedFirst.com

To exercise the above rights, please contact the individual listed at the top of this Notice to obtain a copy of the relevant form you will need to complete to make your request.

Section F: Changes to This Notice

· We reserve the right to change this Notice:

We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice. The Notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register at or are admitted to the Provider for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current Notice in effect.

Section G: Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Provider or with the Secretary of the Department of Health and Human Services; http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

To file a complaint with the Provider, contact the individual listed on the first page of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Section H: Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Section I: Organized Healthcare Arrangement

The Provider, the independent contractor members of its Medical Staff (including your physician), and other healthcare providers affiliated with the Provider have agreed, as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations. This enables us to better address your healthcare needs.

Revision Date: March 03, 2013, to be compliant with HIPAA Omnibus Privacy Rules. • Original Effective Date: April 14, 2003



Patient Name:
D.O.B/
Acct #:
Do you authorize Med First to obtain the last 13 months of your medication history from your insurance carrier and or pharmacy?
Yes
□No
signature/ date

date

witness