Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule:

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices. We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a revised copy be sent to you in the mail, or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure – This means we will only use or disclose your PHI as described in this Notice unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/ phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI* – This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in

electronic for- mat. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI* – This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information* – This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability* – You may submit a written request for a listing of dis- closures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice – You have the right to receive written notification if the practice discovers a breach of your unsecured PHI and determines through a risk assessment that notification is required.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment – We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment – Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health- care services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations – We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality

assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Insurance Coverage

It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions, authorization and limitation requirements. This information can be found by calling your insurance company or visiting their website. If insurance is not valid at the time of your visit, all financial responsibility will then become the patients or the responsible party.It is your responsibility to give us updated information and new insurance information as soon as you receive it.

Co-Payments, Co-Insurance and Deductibles

All co-payments, co-insurance and deductibles are the patient's responsibility. Co-payments are due at the time of each visit. Deductibles are patients' responsibility. You will be asked for a portion of your deductible upfront prior to your visit or procedure, in the amount of $75. Patient balances will be collected prior to check-in.

Non-Covered Service

You are responsible for any and all "non-covered" services if denied by your insurance carrier.

Insurance Request

You are responsible for promptly responding to any request from your insurance company for further information. Not doing so will result in a claim denial and you will then be responsible for payment.

Insurance Payments Sent To You

If insurance payments are sent to you, it is your responsibility to forward them to our office with any documentation or explanation of benefits pertaining to the claim.

Collection Accounts

If your account is sent to our collection agency, it is your responsibility to pay all attorney fees, if applicable.

Payment Due at Time of Service

We accept cash, debit and credit cards.
Patient balances are due at the time of check-in unless payment agreements have been arranged with the office manager.

Self-Pay

We will make every attempt to collect payment upfront for the services that you will receive. In some cases, after being evaluated by
the Provider an additional or alternative lab test may be required. In that circumstance, you will be balance billed for the remainder of
the lab fees after the visit.

Consent to Treat

You have the right to accept or reject treatment recommended by your Provider.
It is very important that you provide the doctor with an accurate medical history before, during, and after treatment. It is equally important that you follow the doctor's advice and recommendations regarding medication, pre- and post-treatment instructions, referrals to other doctors or specialists, and return to the appropriate provider for follow-up appointments.

Possible Treatments to be Provided

I understand that during my course of treatment that any or all the following care may be provided, as recommended by the medical provider: Examinations; Medications (oral, topical, ocular, rectal, intramuscular, subcutaneous, intravenous, and/or by inhalation); Wound Care (sutures or other closures, burn treatment, and/or bandages); Specimen Collection (fingerstick, blood draws, urine samples, stool samples, and/or mucosal swabs); Laboratory Testing; Physical Examinations for sports, school, camp, and/or employment.
I understand that I will be provided with information about each recommended treatment before beginning any such recommended
procedure or treatment.

Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while my assessment and treatment that were not discovered during the initial examination. I give my permission to the doctor to make changes and additions as necessary.

Benefits and Risks of Recommended Treatment

No medical treatment is completely risk free. I understand that the doctor will take reasonable steps to limit any complications of the treatment recommended, and that they will explain the benefits and risks of treatment before proceeding. I further understand that I will have the opportunity to have all of my questions about these benefits and risks answered to my satisfaction before proceeding
with treatment.

Alternatives to Recommended Treatment

I understand that there may be alternatives to the treatment option recommended by the doctor (including having no treatment), and that these alternatives will be explained to my satisfaction. I

further understand that I will have the opportunity to have all of my questions about alternative treatment answered to my satisfaction before proceeding with treatment.

Consent to Care by Non-Physician Providers

I acknowledge and consent to receive medical evaluation and treatment from a qualified Nurse Practitioner (NP) and/or Physician Assistant (PA), even in the absence of an on-site physician. I understand that while a physician may not be physically present during my visit, they are available for consultation and oversight and can be reached promptly by phone should the need arise. I agree to this model of care and understand that it is consistent with accepted standards of medical practice.

Higher Level of Care Required:

If a patient has been evaluated by the Provider and requires a higher level of care and is referred out to another facility (i.e. Urgent Care/ER/Hospital/Imaging), the patient is still financially responsible for the initial visit with SmartMED, LLC.

Diagnosis and Results

I authorize SmartMED Drive-Thru's office to contact me by mobile phone and to leave a message with regards to my diagnosis and treatment.