Lisa E. Medwedeff, M.D. • Gracie Martinez, APRN FNP-C . • Winona Tzou, APRN FNP-C

Legacy Medical Village • 5425 West Spring Creek Parkway • Suite 210 • Plano, TX 75024

Phone (972) 608-3333 • Fax (972) 473-7333 • www.villageimg.com

CONTACT INFORMATION

Date: ____/_____/_____

Do You Use Mail Order For Rx?

YES NO

First Name:___________________________________Last Name: ____

Address:____ Apt/Unit #: ____________

City: ____________________________State: ________ Zip: ____________ ____________

Best Contact Number:______________________________( ) Home ( ) Work ( ) Cell

Second Best Number:______________________________( ) Home ( ) Work ( ) Cell

Email: ____

Please Provide PHARMACY

Name: ________________________________

Location: ______________________________

Phone: ________________________________

Please provide two Emergency Contacts:

Name:____Phone: ____________________________

Name:____Phone: ____________________________________

Date of Birth: _________/______/______ **AGE:** (_______) **Social Security Number:** _____________-_______-___________

Marital: ( ) Single ( ) Married ( ) Divorced ( ) Domestic Partner

Gender: ( ) Male ( ) Female

Race: ( ) Caucasian ( ) African American ( ) Hispanic ( ) Oriental ( ) American Indian ( ) Arabic ( ) Other

Employment Status: ( ) Student ( ) Employed ( ) Looking ( ) Full-Time In Home ( ) Retired

Employer: ____ **Position:** ______________________________

How did you hear about Dr. Medwedeff – Dr. Wills? ____

Name of Insurance Company: ____

Subscriber ID:____ **Group No:** ________________________________

Primary Insured:( ) Self ( ) Spouse:__________________________________( ) Parent: _____________________________________

Birth Date of Primary Insured: _____________________________________

I authorize Village IMG to disclose all or part of my patient records to my insurance company or other medical associations such as physicians, labs, or clinics, as such information may be necessary for the completion of insurance claims.

I understand and agree that after 45 days of non-payment by my insurance for any reason, I become fully and immediately responsible for all charges incurred during my office and/or hospital visit(s). I agree that unpaid claims after 90 days from the date of service may be sent to a collection attorney if I fail to pay, and will likely have a negative effect on my credit standing.

I authorize payment from insurance to be made directly to Village IMG (assignment of insurance benefits). I waive this assignment if my insurance fails to pay within 45 days from the date of service as a breach of contract.

Signature:____**Date:** ______________________

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PATIENT INFORMATION AND NOTIFICATION

I would like to ask you to take a few minutes to read over the policies and procedures we have chosen to operate Village IMG. Please help us by understanding there are many unique considerations and aspects of the solo primary care medical practice. We need to implement guidelines in order to continue to provide quality patient care and protect the ability to continue as a solo practice. By working together, we can establish strong patient relationships that can remain autonomous while meeting patients' needs with the highest degree of excellence. Without some basic standards of operation, we will certainly be taken under by a healthcare system that is working against us. By reading and signing below, you are stating that you have been provided and understand our office policies and procedures put in place to ensure our ability to provide the best levels of service and care for our patients.

Thank you in advance for your understanding and cooperation.

APPROVED HIPAA CONTACTS

Disclosure of Protected Health Information

Keeping patient information private is important to us. Our policy is to only disclose patient information (billing and medical condition), to the patient or legal guardian. This includes a spouse or adult child who you might want Village IMG to discuss medical findings with or involve in your treatment plan. If there are additional people whom you would like to have access to this information, please fill out the form provided in this packet.

WRITTEN CORRESPONDENCE

We can only provide written correspondence in three ways: via the patient portal, US Mail, or in person. We cannot provide statements, test results, or other medical information through e-mail.

INSURANCE

Even though this information is stored in our computer system, insurance changes frequently and we need to be absolutely sure we have your latest coverage updated and that we file correctly. Please be prepared to show us your insurance information on each visit.

Healthcare Insurance can be confusing. Keep in mind the following:
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- We are only contracted with select insurance plans. Contact your insurance carrier to confirm Dr. Medwedeff or Dr. Wills is a "preferred provider" or "in network."
- We will contact your insurance carrier for benefits; however, it is your responsibility to know your benefits and coverage.
- We will submit your insurance claims on your behalf.
- After filing with your insurance there are several possible outcomes:
  - The claim will be paid and you will receive a statement for the portion your contract allows but does not pay in full.
  - All or part of the claim may be applied to your deductible and you will be responsible for the balance.
  - They may deny the claim. If this happens: You will need to contact your insurance carrier (not our office) for the denial reason and what, if anything, can be done to get the claim paid. Once you do this, let us know, and we will resubmit the claim. If it is still denied, you will be responsible for all allowed charges.

Texas law now requires commercial insurance carriers to pay medical claims within 45 days. If they do not, it will then be your responsibility to pay the professional services in full. Should we receive a subsequent payment from your insurance carrier, we will provide a refund by check or a refund your credit card.

SCHEDULING

Excellent medical care takes time to diagnose and treat. Sometimes our schedule is delayed when patients require more attention than originally anticipated. We ask for your patience in waiting, realizing that you will receive the same high level of care.

ANNUAL PHYSICALS / GYN EXAMS

If you advise that you're coming in for a physical or a Gynecological (GYN) exam, we will bill the office visit and lab as "routine wellness". If your plan does not cover these services, you will have to pay in full. If you require services beyond "routine wellness" at the same time, an additional office visit charge will be added.

LATE ARRIVALS/NO SHOW

- The first appointment in the morning and afternoon are reserved for individuals who have tight schedules and need to be seen promptly. We have a zero tolerance for late arrivals for these choice times.
- All appointments need to be rescheduled if you're running more than 15 minutes late unless we have had a cancellation and can accommodate your visit into our schedule.
- Patients more than 20 minutes late will be considered a no-show and an appropriate charge will be assessed.
- If you "no show" for three appointments, written notice will be sent to you terminating you as a patient.

CANCELLATIONS

Please provide us with 24 hours advance notice if you need to reschedule an appointment. This can be done via phone or patient portal. Failure to do so will incur the following charges based on the amount of time previously reserved:

- 15 – 25 minute appointments $25.00
- Physical/GYN exam $50.00
- Procedure visit such as minor surgery or diagnostic testing $75.00

LAB

Our electronic health records (EHR) are interfaced with Clinical Pathology Laboratory (CPL) and Quest. For this reason, these are our preferred laboratories.

PATIENT PORTAL

You have partial access to your medical records via the secure patient portal. You can review all documented diagnosis, medications, medication allergies, and most test results. Messages can be sent and will be addressed within 48 hours (during regular business hours.) All non-emergency communication should take place via the patient portal as opposed to email or phone calls

STATEMENTS

- Statements are due upon receipt.
- Late fees (1.5% total due) may be added if payment has not been received within 30 days from the date of the statement.
- Payments due for more than 90 days are subject to collection.
- Payments may be made at any time via phone with Visa or MasterCard.

ADDITIONAL ITEMS:

- Health forms to be completed (outside of office visits) will have a charge of $25.00 per page.
- Letters requested of Dr. Medwedeff will be charged based on complexity and time, starting at $40.00.
- Copies of medical records are charged according to the Texas Medical Examiners fee schedule which is $25 for the first 20 pages and $0.50 per page thereafter.
- Letters mailed at patient's request are $1.00.

I have read and understand the above policy and procedure:

____

Patient Signature

____

Today's Date

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PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of healthcare services that Village IMG creates and maintains health records describing among other things my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging medical review, legal services, auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and healthcare operations. I have listed below the names of others that may have access to my personal health information. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written, oral, or electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment, or healthcare operations without prior written authorization, except as otherwise provided by the law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or healthcare operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

PRIVACY DISCLOSURE OF MEDICAL INFORMATION
(circle YES or NO)

I approve the receipt of a FAX with medical information: YES or NO

I approve the receipt of an E-MAIL with medical information: YES or NO

I approve the receipt of a TEXT MESSAGE with medical information: YES or NO

I approve the receipt of a VOICEMAIL with medical information: YES or NO

____________________________________ ________________
Printed Name of Patient Date of Birth

____________________________________ ________________
Patient Signature Date

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

______________________________ ______________
Patient Name Date of Birth

I, the above mentioned, release the following medical information:

_____ All medical records

_____ All billing records

Information can be released and sent to the following people authorized to receive information:

______________________________ ______________
Name Relationship

______________________________ ______________
Name Relationship

______________________________ ______________
Name Relationship

I, the above mentioned, release Village Internal Medicine Group, and the staff, from any liability concerning my medical records.

______________________________ ______________
Patient Signature Date

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Physical Exam History: MALE

Today's Date: ____________________

Name: ____________________

Date of Birth: ____________________

Age:__________years

Insurance Name ____________________

Email Address: ____________________

Family History: Please state significant disease of family members and age of diagnoses and age of death (i.e. Diabetes, high blood pressure, Cancer, heart disease, Stroke, etc…) Circle either (A-alive, D -deceased)

Father -____________________ A D

Mother -____________________ A D

Brother -____________________ A D

Sister -____________________ A D

Maternal Grandfather-____________________ A D

Maternal Grandmother-____________________ A D

Paternal Grandfather-____________________ A D

Paternal Grandmother-____________________ A D

Social History: (circle answers and/or write comments)

Occupation/Profession:____________How Long?____yrs Hrs/week: ____

Marital Status: *single, married, widowed, divorced, separated, engaged, domestic partner* Comment? ____________________

How many children? ____________________
Their ages: boys________________ girls________________

Do you **use sunscreen**? Yes / No

Alcohol: *none / rarely / occasional / everyday* #_____drinks/week?
Preference of alcohol ____________________

Sexually active? *Yes / No* **History > one partner**? *Yes / No*
Do you practice safe sex? *Yes / No*
Sexual Orientation: Heterosexual / Homosexual
Have you ever had sexually transmitted infection(s)? *Yes / No*
Do you want HIV/AIDS screening? Yes / No

Are you on a special **Diet**? *Yes / No*
Type: ____________________

Exercise: *none / rarely / intermittently / regularly*__________days/ *wk* or *mo*
Aerobic__________min/day. Walk__________________min/day
Weights__________min/day. Other ________________

Weight change in last 6 months: *no change / gained / lost*
pounds?______. Is the reason for this change obvious to you? *Yes / No*
Comments? ____________________

Have you ever used illegal drug(s)? *Yes / No*
If yes, what drug(s)? __________ How many years? _____years

( ) Never smoked ( ) Smoked______packs/day for______years.
I quit smoking__________years ago.
I **have** or **have not** tried to quit. If yes, what method?________________
Cigars? Yes/No **Chewing Tobacco** Yes/No **E-Cig** Yes/No

Immunizations:	**Month/Year**	**Immunizations:**	**Month/Year**
Tetanus (Tdap)	_______	*Covid*	_______
Pneumonia 23	_______	*Hepatitis A*	_______
Pneumonia 13	_______	*Hepatitis B*	_______
Shingle (Zostavax)	_______	*PPD (TB Skin Test)*	_______
Influenza	_______		
Gardasil/HPV	_______		

Previous Physical Exams: (circle answers and/or write comments)

Last **Physical**: date__________Was exam: *abnormal / normal*

Comment?____________________

Last **Rectal/Prostate Exam**: Date________________

Was exam: *abnormal / normal*

Comment____________________

Vasectomy? Yes / No Date:________________

Last full **blood work**: date__________Was anything abnormal? *Yes / No*

Comment____________________

Last **chest x-ray**: date__________ Was anything abnormal? *Yes / No*

Comment____________________

Last **EKG**: date________________ Was: *abnormal / normal*

Last Heart **Stress Test**: date____________Was: *abnormal / normal*

Coronary Calcium Score date________________Score__________

Last **Colon Screening** test: date:____________________

Perform by (**Physician**)____________________

Type: *stool card / sigmoidoscopy / colonoscopy*

Was: *abnormal / normal*

Finding (*polyps*?)________________Repeat in____________years

Last **Bone Density**: date______________ Was: *abnormal / normal*
Osteopenia/ Osteoporosis Facility performed at?________________

MRI/CT scan of?____________________When?____________
Was: *abnormal / normal*

Last **Foot** Exam?: date_______

Last **Eye** Exam?: date_______

Last **Dental** Exam? date_______

Last **Sonogram** of:____________________
(example: Thyroid, Abdominal, Carotid, Venous Doppler etc.**)**
date____________________

Other Tests: type____________________, when? ____________

Past Medical History: Have you ever had the following? (Circle all that applies.)

ADD
AIDS/HIV
Alcoholism
Allergies/ Hay fever
Anemia
Anorexia
Anxiety
Asthma
Back pain, chronic
Breast Cancer
Other Cancer: _________
Depression
Diabetes Type I
Diabetes Type II
Diabetes, gestational
Diverticular disease
Eczema/ Hives
Emphysema
Erectile dysfunction
Fibromyalgia
Gallbladder/Stones
Genital herpes
Glaucoma
Heart Attack
Heart disease
Hemorrhoids
Hepatitis
Hernia
High cholesterol
High blood pressure
Irritable bowel
Kidney stones/disease
Liver Disease
Migraine
Mitral valve prolapse
Obesity
Osteoporosis/ Osteopenia
Pneumonia
Prostate enlargement/ Cancer
Reflux
Rheumatic Fever
Rheumatoid Arthritis
Seizure Disorder
Sleep Apnea
Stroke
Thyroid Disease
Tobacco use
Tuberculosis
Ulcer
Venereal Disease

Health Problems in Last 6 Months: (circle and/or write comments)

Y N **Problems with urinary tract (kidney, ureters, bladder)?**

Y N **Loss of control of your bladder?** *Date began?* ___________

Y N **Pain or burning with urination?** *Currently? Yes / No*

Y N **Frequent urination?** *Currently? Yes / No Date it began*_____________

Y N **Do you have to push or strain to start urination?**

*Date began*_____________

Y N **Enlarged or Abnormal Prostate?** *Date found?*________________.

*Comment*____

Y N **History of Acute or Chronic Prostatitis?** *Currently? Yes / No Date began?*________________*Treated by a Doctor? Yes / No*

Y N **Pain in Penis, Testicles, or Scrotom?** *Date began*_______________

Y N **Lump in Penis, Testicles, or Scrotom?**

Y N **Decreased ability to have an erection?**

*Date first noted*_______

Y N **Pain with Intercourse?** *If currently, Date it began*_________________

Y N **Previous history of sexual transmitted disease?**

*Type?*__________. *When discovered*___________. *Treated? Y/N*

Y N **Rectal Pain or Rectal Bleeding?** *Currently? Yes / No Has this been addressed by a doctor? Yes / No*

Y N **Hemorrhoids? Currently?** Yes/ No
Has this been addressed by a doctor? Yes / No

Please give your reason(s) for coming in today or health concerns that you want addressed:

____

____

Allergies to Medication: (give name of medication and type of reaction, for example, upset stomach, rash, respiratory distress.
Example: *Penicillin – hives, swelling and joint pain)*

1.____________________
2.____________________
3.____________________
4.____________________
5.____________________
6.____________________
7.____________________
8.____________________
9.____________________
10.____________________

Medical Problems / (Past Diagnosis) :
(Asthma, Diabetes, High Blood Pressure, Reflux, High Cholesterol, Allergies, Arthritis, etc…)

1.____________________date began__________
2.____________________date began__________
3.____________________date began__________
4.____________________date began__________
5.____________________date began__________
6.____________________date began__________
7.____________________date began__________
8.____________________date began__________
9.____________________date began__________

Operations: (gallbladder, hysterectomy, appendix, hernia, vasectomy, mastectomy, polypectomy, etc…)

1.____________________date__________
2.____________________date__________
3.____________________date__________
4.____________________date__________
5.____________________date__________
6.____________________date__________
7.____________________date__________
8.____________________date__________
9.____________________date__________
10.____________________date__________

Current Medications: (Name, Dosage, How often)

(ex. Benicar HCT 40mg- 12.5mg 1 pill twice daily)

1.____________________
2.____________________
3.____________________
4.____________________
5.____________________
6.____________________
7.____________________
8.____________________
9.____________________
10.____________________
11.____________________

Hospitalizations: (give reason and month/year)

Reason Mo/Yr

1.____________________
2.____________________
3.____________________
4.____________________
5.____________________
6.____________________
7.____________________
8.____________________
9.____________________
10.____________________
11.____________________

Review of Systems:

Circle all that apply to you, include onset date, current status, and severity

- General:
  Sense of well-being: Good / Poor
  Energy Level: Good / Poor
  Fever – Chills – Night Sweats – Swollen Glands – Weight Loss – Weight Gain – Change in Sleep
- Skin:
  Acne – Changing Moles – Lumps – Rashes – Eczema – Psoriasis – Skin Lesions
- Eyes:
  Blurred/Double Vision – Pain
- Ears:
  Decreased Hearing – Ringing – Change in Hearing – Hearing Aids
- Nose:
  Bleeding – Polyps – Deviated Septum – Sinus – Allergies
- Throat/Mouth:
  Swollen Glands – Canker Sores – Dry Mouth – Dentures – Snoring
- Pulmonary:
  Wheezing – Short of Breath – Cough
- Heart:
  Chest Pain – Rapid / Irregular / Skipped Heartbeats – Decreased ability to exercise – Swollen Ankles – Leg pain when walking – Short of breath
- GI:
  Nausea – Indigestion – Vomiting – Diarrhea – Cramps – Constipation – Hemorrhoids – Change in Appetite –
  Increased Gas / Bloating – Bloody / Black Stools –Abdominal Pain– Mucous in Stools
- GU:
  Painful Urination – Frequent Infections – Bloody Urine – Difficulty Starting / Stopping Stream – Leakage – Excessive Night Urination (# times/night______) –
  Prostate Problems – Genital Lesions – Discharge – Sexual Dysfunction – Dribbling with Urination – Hard Testicle – Hernia – Penile Discharge
  Rash or Blisters on Penis – Scrotal Pain
- Endocrine:
  Heat / Cold Intolerance – Excessive Thirst – Excessive Urination – Excessive Dry / Oily Skin – Excessive Hair Growth / Loss
- Hematology:
  Easy Bruising / Bleeding – Clotting Disorder – History of Transfusion
- Neuro: Headaches (# per month_______________)
  Changes in Smell/Taste – Changes in Behavior – Changes in Vision– Dizziness
- Psych:
  Feeling Helpless / Hopeless – Anxious – Irritable – Emotional – Depressed – Thoughts of Suicide or Death
- Musculo-Skeletal:
  Muscle Aches/Cramps – Swollen Joints – Tender Joints
- Hematology:
  Clotting Disorder – Easy Bruising / Bleeding – History of Transfusion

Do you have any other physicians?

Allergist:_________________________ Neurologist: _________________________ Psychiatrist: __________________________

Cardiologist: ____________________ ENT: _______________________________ Pulmonogist: _________________________

Chiropractor: ____________________ Rheumatologist: _____________________ Urologist: ____________________________

Dermatologist: ___________________ Ophthalmologist:_____________________ General Surgeon: _____________________

Dentist: _________________________ Orthopedic Surgeon: _________________ Other: ____________________________

Endocrinologist: _________________ Pain Management: ____________________

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For the following questions, please answer with this scale:

	Poor	Fair	Good	Very Good	Excellent
Overall, describe your health.					
Overall, describe your quality of life.					
Overall, describe your mental health, taking into consideration of your mood and cognitive ability.					

For the follow questions, please answer Yes or No.

	Yes	No
Have you experienced urinary incontinence within the past 6 months?		
Have you fallen within the past 12 months?		
Do you have any issues with hearing or are you perceived to have hearing issues?		
Does your eyesight hinder your ability to read, watch television, drive, or perform any other day-to-day tasks?		

In your home, have the following safety measures been taken?

	Yes	No
Secured loose rugs and/or carpets		
Functioning carbon monoxide detector		
Functioning smoke alarm		
Well-lit walking areas		
Sturdy stair rails		
Anti-slip floors in shower/bathtub or grab bars in bathroom		

Please describe your ambulation/mobility status (Please list any use of mobility assistive devices – i.e., cane, walker, wheelchair, mobility scooter):

____

Mode of transportation:

____ I drive myself ____ Someone else drives me ____ I use public transportation (i.e., Uber, Lyft, etc.)

What is the typical serving of vegetable and/or fruits you consume daily?

____ >5 servings ____ 3-5 servings ____ 1-2 servings ____ None

	Yes	No
Do you have an Advance Directive (power of attorney and living will)?		
If yes, do you have your Advance Directive in your records with us?		

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Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	**Independence** (1 Point) **NO** supervision, direction, or personal assistance.	**Dependence** (0 Points) **WITH** supervision, direction, personal assistance or total care.
BATHING Points: ______________	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area, or disabled extremity.	(0 POINTS) Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
DRESSING Points: ______________	(1 POINT) Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
TOILETING Points: ______________	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: ______________	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable.	(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: ______________	(1 POINT) Exercises completes self-control over urination and defecation.	(0 POINTS) Is partially or totally incontinent of bowel or bladder.
FEEDING Points: ______________	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 POINTS) Needs partial or total help with feeding or requires parental feeding.
TOTAL POINTS: ______________	SCORING: 6 = High (*patient independent*)	0 = Low (*patient very dependent*)

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EXPLANATION OF COMPLETE PHYSICAL EXAM

A physical exam is a critical part of your healthcare provided by Village IMG. The frequency of the exam is determined by Village IMG, based on your age and overall health.

Insurance plans, as determined by your policy or your employer, have vastly different benefits for routine exams. In some cases, insurance will not cover routine care at all (or "well patient" or "preventative care" office visits.)

Prior to your visit, we encourage you to contact your insurance company to see what benefits are included for a routine physical exam (to include lab work, mammogram, chest x-ray, EKG, PFT, stress test.) Benefits may be different if performed at another location.

_________ *(initial here)* ***If you are scheduled for a routine physical and wish to address issues outside of routine care, insurance may or may not cover charges for additional consultation and non-covered charges will be billed to you. In some cases, insurance companies would rather you return on another day to discuss your on-going health concerns.***

These are the directives of insurance companies, not our office. We simply want you to be informed and know your potential financial exposure for non-covered benefits as well as make you aware of the possible need for multiple appointments.

PLEASE SIGN THE WAIVER BELOW FOR POSSIBLE NON-COVERAGE OF SERVICES.

I understand my insurance company may or may not fully cover routine/preventative care services performed in and outside of our office, as ordered by Dr. Medwedeff, as part of my complete physical exam. I acknowledge this and understand it is my responsibility to understand the application of my benefits in this situation. I understand that I am responsible for a charges not covered by my insurance company.

___________________________________ ______________
Signature of Patient Date

<u>Village Internal Medicine Group</u>

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. **<u>Uses and Disclosures of Protected Health Information</u>**

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your physician to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

<u>Treatment:</u> We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

<u>Payment:</u> Your protected health information will be used, as needed, to obtain payment for your health care 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, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

<u>Healthcare Operations:</u> We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you. We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

<u>Others Involved in Your Healthcare:</u> Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care. **<u>Emergencies:</u>** We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you. **<u>Communication Barriers:</u>** We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority. **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition. **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws. **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws. **Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required. **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process. **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred. **Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes. **Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information. **Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual. **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized. **Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs. **Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you. **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by signing this information on the bottom of your demographic profile.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Contact, Tim Miller at (972)608-3333. This notice was published and becomes effective on April 14, 2003.