PATIENT REGISTRATION

GASTRO HEALTH

2793 Shawnee Road ● Lima, Ohio 45806
Phone (419) 227-8209

HISTORY & PHYSICAL WILL BE DONE

Pt. Acct.#_____

NO PROCEDURE WILL BE DONE ON THIS DAY

YOU ARE SCHEDULED TO SEE: DR KURLAND / DR NEIDICH / DR PATEL / DR RINEMSMITH / DR SHEIKH / DR SOLOMON
KELSEY BROKAMP, CNP / JULIE GARVER, CNP / LAURIE KNIPPEN, CNP / STACY MILLER, CNP
CARRIE STOLLER, CNP / KRYSTAL UMFLEET, CNP / NICHOLA WARNECKE, CNP

PLEASE COMPLETE AND BRING THIS FORM WITH YOU TO YOUR APPOINTMENT

******This form must be completed before you see the provider. If this form is not fully completed, please arrive a half hour before your appointment time**

Name _____

Social Security # _____

Age _____ Date of Birth _____

Address _____

_____ Zip _____

Phone Number _____

Occupation _____
(If retired, list prior work)
Place of Employment _____

Address _____

Business Phone _____

Name of Preferred Pharmacy _____
Town / City _____
Phone Number _____

REFERRING PHYSICIAN _____

FAMILY PHYSICIAN _____

Weight Change in past 6 months:
Height _____ Weight Gain _____ pounds
Weight_____ Weight Loss_____pounds

For what problem are you seeking care? _____
_____
If pain is present, please describe:
How often _____
Severity (1: minimal – 10: severe) _____

Health Insurance: Please bring card(s)

***Primary* Carrier** _____
Address _____
Certif/ID # _____
Group # _____
Policy Holder's Name _____
Policy Holder's SSN ___ _____
Policy Holder's Birthdate _____
Policy Holder's Employer _____

***Secondary* Carrier** _____
Address _____
Certif/ID# _____
Group # _____
Policy Holder's Name_____
Policy Holder's SSN _____
Policy Holder's Birthdate _____
Policy Holder's Employer _____

Marital Status _____
Religion (Optional) _____

Spouse or Next of Kin / Emergency Contact:
Name: _____
Relationship _____
Address _____
Home Phone _____
Occupation _____
(If retired, list prior work)
Place of Employment _____

Business Phone _____

How long has this problem been present? _____
Quality (i.e. sharp, dull, crampy, burning, achy, etc.) _____
Does the pain move anywhere? _____
What makes the pain worse? _____
What makes the pain better? _____

Approximate Date of Last:

Physical Exam _____
Electrocardiogram _____
Chest X-ray _____
Barium Enema _____
Gallbladder _____
Sigmoidoscopy _____
Colonoscopy _____
GI Series _____

Do you have a history of heart valve problems or need antibiotics before procedures? _____

List Drug Allergies _____ None Known _____

Do you have a history of allergy or reactions to X-ray dye or iodine? _____ None Known _____

Are you sensitive / allergic to Latex? _____

List Chronologically ALL Operations and ALL Hospitalizations

Approx. Date	Operation and/or Hospitalization	Hospital	Doctor

(List additional hospitalizations / operations on back of pg. 3 or on a separate sheet of paper)

BRING CURRENT MEDICATIONS WITH YOU OR LIST ALL MEDICATIONS/DOSAGES TAKEN ON PROVIDED MEDICATION LIST PAGE – to include aspirin, Motrin, Advil. Aleve, other "pain" medications, vitamins, laxatives, antacids and birth control pills.

Coffee _____ cups / day Tea _____ cups or glasses / day Tobacco _____pk/day for ____yrs.

Soft Drinks _____oz. / day Chocolate: Form _____ Amount _____

Alcohol: Type _____ Amount_____ Street Drugs _____

FAMILY HISTORY:

	Sex	Age	State of Health and Diagnosis	Age at Death and Cause of Death
Father	**M**			
Mother	**F**			
Brothers & Sisters				
(List additional brothers and sisters on a separate sheet of paper)				
Father's Father	**M**			
Father's Mother	**F**			
Mother's Father	**M**			
Mothers Mother	**F**			
Spouse				
Children				
(List additional children on a separate sheet of paper)				

Is there any history of <u>colon polyps</u> or <u>colon cancer</u> in your family? ڤ **YES** ڤ **NO**

If YES, please list how related:_____

Have you ever had or been treated for: CIRCLE problems you are currently having and UNDERLINE those you have had previously

General: Fever, chills, weight loss, night sweats.

Eyes: Cataracts, double vision, glaucoma, pain on exposure to light, loss of vision, glasses, contact lenses.

Ear, Nose, Throat: Hearing loss, sinus infections, nasal polyps, hoarseness.

Cardiovascular: High blood pressure, heart disease, heart murmur, angina, chest pains, rheumatic fever.

Respiratory: Pleurisy, TB, coughing up blood, asthma, emphysema, bronchitis, shortness of breath, chronic cough, sleep apnea

Gastrointestinal: Swallowing trouble, heartburn, belching, gas, duodenal or gastric ulcer, abdominal pain, liver disease, jaundice, hepatitis, gallbladder disease, nausea, vomiting, constipation, diarrhea, black stools, blood in stools, change in bowel habits, incontinence (loss of control of bowel movements).

Genitourinary: Kidney or bladder infections, blood in urine, kidney stones, nephritis, incontinence, prostate trouble, sexual problems, sexually transmitted disease, extramarital activity, homosexual activity.

Gynecologic: Abnormal menstrual bleeding, irregular periods, painful intercourse, frequent pelvic infections, endometriosis. List date of last menstrual period _____

Musculoskeletal: Painful or swollen joints, arthritis.

Skin and Breast: Rashes, psoriasis, melanoma, tattoos, breast lumps, breast cancer, skin cancer.

Neurologic: Frequent headaches, migraines, epilepsy, seizures, passing out or dizzy spells, numbness or tingling of arms or legs, stroke.

Emotional: Sexual, physical or emotional abuse, depression, anxiety, excessive nervousness, marital problems, crying spells, suicidal thoughts, in-law problems, financial problems.

Endocrine: Diabetes, thyroid disease.

Blood: Anemia, bleeding disorder, blood or blood product transfusion.

Allergic/Immunologic: Lupus, HIV (AIDS)

Cancer: Any previous cancers. List type _____

MEDICARE AND MEDICAL ASSISTANCE

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medical Assistance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physical services to the physician(s) or organization furnishing the services or authorize such physician(s) or organization to submit a claim to Medicare or Medical Assistance for payment to me.

ALL OTHER INSURANCE

I hereby authorize Gastro Health (formerly Gastro-Intestinal Associates, Inc.) to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment directly to the physician(s) rendering the covered services. I authorize Gastro Health (Formerly Gastro-Intestinal Associates, Inc.), to furnish complete information to my insurance carrier or its intermediaries regarding services rendered. I understand I am financially responsible for all charges not covered by this authorization. This authorization shall remain in effect until revoked in writing by the signatory or his/her legal representative.

_____ _____

Signature Date

PLEASE FILL OUT MEDICATION LIST FOR OUR CHART THANKS!

DATE:

NAME:

PLEASE LIST ALL MEDICATIONS, OVER THE COUNTER DRUGS, HERBAL SUPPLEMENTS AND VITAMINS BELOW

IF YOU ARE NOT TAKING ANY OF THE ABOVE, PLEASE CIRCLE: NONE

EXAMPLE: NEXIUM	**40mg 1 tab once daily**
MEDICATION	**DOSAGE**

GASTRO HEALTH (FORMERLY GASTRO-INTESTINAL ASSOCIATES, INC.)
PATIENT ACKNOWLEDGEMENT OF DISCLOSURES, PRIVACY PRACTICES AND FINANCIAL POLICY

Patient Name: _____ DOB: _____

Parent/Guardian (if applicable): _____

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

1) I wish to be contacted in the following manner (check all that apply):

□ **Home Telephone** _____
- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only

□ **Work Telephone** _____
- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only

□ **Written Communication**
- □ O.K. to mail to my home address
- □ O.K. to mail to my work/office address
- □ O.K. to fax to this number _____

□ **Person(s) with whom we may share your information**
_____
_____

□ **Email Address** _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

2) I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

3) I have received the Practice's Financial Policy.

Patient Signature: _____ Date: _____

GASTRO HEALTH (FORMERLY GASTRO-INTESTINAL ASSOCIATES, INC.)

2793 Shawnee Rd. Lima, OH 45806
Phone # 419-227-8209 Fax # 419-222-6007

AUTHORIZATION FOR OBTAINING, USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Gastro Health (Formerly Gastro-Intestinal Associates, Inc.) to
(check the following that apply):

_____ obtain **the following health information from**
_____ disclose the following health information to
_____ use the following protected health information for
_____
_____
_____

This protected health information is being used or disclosed for the following purposes:
treatment, payment and/or healthcare operations

This authorization shall be in force and effect from the date signed until written notification revoking this authorization has been received.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Ms. Pat Schnipke at Gastro Health (formerly Gastro-Intestinal Associates, Inc.). I understand that a revocation is not effective to the extent that Gastro Health (Formerly Gastro-Intestinal Associates, Inc.) has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Gastro Health (Formerly Gastro-Intestinal Associates, Inc.) will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative DOB

_____
Description of Personal Representative

Re-scheduling fee: We will gladly re-schedule a procedure for you one time at no charge. However, the second time we are asked to re-schedule a procedure at your request there will be a $10 service fee. This fee is due before re-scheduling the procedure.
Completion of forms: Due to a significant increase in requests for completing paperwork and forms, a fee of $10 will be charged for completing of these items (e.g. work release, disability insurance etc.). Exclusions to this policy are forms completed for Medicaid and Worker's Compensation.
Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of the account balance to a lawyer, you agree to pay all lawyer fees which we incur plus court costs. In case of suit, you agree the venue shall be in Allen County.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may contact you by sending text messages or e-mails you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor may contact me/us as described above.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become matter of public record.
Transferring of records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.
Worker's Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.
Personal injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we will require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangement may be discussed. Payment of the bill remains the patient responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.
Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

I have received a copy of the HIPPA Privacy Act.

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance company.

Medicare and Medical Assistance: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or it's intermediaries or carriers any information needed for this or a related Medicare or Medical Assistance claim. I request that payment of authorized benefits be made on my behalf. I assigned the benefit made on my behalf. I assign the benefits payable for physical services to the physician(s) or organization furnishing the services to authorize such physician(s) or organization to submit to Medicare or Medical Assistance for payment.
All Other Insurance: I hereby authorize Gastro Health (Formerly Gastro-Intestinal Associates, Inc.) to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or it's intermediaries to issue payment directly to the physician(s) rendering the covered services. I authorize Gastro Health (Formerly Gastro-Intestinal Associates, Inc.) to furnish complete information to my insurance carrier or its intermediaries regarding services rendered. I authorize Gastro Health (Formerly Gastro Intestinal Associates, Inc.) to submit appeals for payment to my insurance company on my behalf. I understand I am financially responsible for all charges not covered by this authorization.
Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be full force and effect.

Patient's Name: _____

Responsible Party: _____

Date: _____

Gastro Health (Formerly Gastro-Intestinal Associates, Inc.)

2793 Shawnee Road
Lima, Ohio 45806
Telephone (419) 227-8209

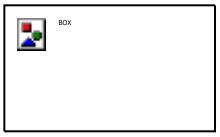
Patient Financial Policy

This is an agreement between Gastro Health (Formerly Gastro-Intestinal Associates, Inc.), and the Patient/Debtor named on this form. In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to Gastro Health (formerly Gastro-Intestinal Associates, Inc.)

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month.
Payment options if you have no insurance: We require a $175 deposit before scheduling a new patient appointment, $100 for a follow up visit and $300 for a procedure prior to treatment being rendered. You are eligible for a 50% discount on services when services are paid upon receipt of the first statement. Your deposit will be applied after the discount. We will extend this discount to anesthesia charged involved with a procedure and Gastro's lab preparation fee for biopsies. You may set up a payment plan with our Financial Department for balances over $200.
Payment options if you have insurance: You may choose to pay your deductible and any out-of-pocket portions at the time services are rendered by cash, check, or credit card. If you have insurance, you must present your insurance card on the day of your visit. If you do not bring your card with you, we will charge you as a private pay patient. Your payment for any deductible or co-payment is due on the day of your appointment. If you are covered under Medicaid, you must present your Medicaid card on the date the service is rendered or your account will be considered self-pay.
Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days of us sending the statement.
Charges to account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.
Fees: Office visit – you will be charged our current fee plus any incidental services your physician may order. Procedures – you will be charged the physician fee and any incidental services you may receive. You will also receive a separate invoice from the facility (e.g. hospital, surgery center, etc.)
Insurance: ***Insurance is a contract between you and your insurance company.*** We are NOT a party to this contract, in most cases. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company might pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, our office will be happy to pre-certify outpatient procedures. *****You are responsible for checking with your insurance company regarding appropriateness of review.*** Failure to obtain the referral and/or preauthorization may result in lower payment from the insurance company and would then be owed by you.
Medicare: We do accept assignment on Medicare. We file the claim and the payment comes directly to us. We will file the claim to your insurance if available. The patients are responsible for the 20% balance after Medicare has processed charges and any deductibles that have been applied.
Medicaid: We do accept Medicaid; however ***you must have your card with you at the time of your visit.***
Credit history: You give us permission to check your credit history and current employment status and to answer questions about your credit experience with us. We have the option to report your account status to any credit-reporting agency such as a credit bureau.
Required payments: Any co-payments required by an insurance company must be paid at the time of service. Any payment that you receive by your insurance company, for our services, must be forwarded to our office.
Returned checks: There is a fee (currently $25.00) for any checks returned by the bank.
Missed appointment fees: Patients who do not show on time for an appointment, or cancel with less than (2) full business day's notice will be charged as follows: $100 for all procedures, $50 for new patient visits and $25 for follow-up visits. A procedure or visit will not be rescheduled until this fee is paid in full. ***This fee cannot be billed to insurance and will be the patient's responsibility.*** **This fee may be waived for circumstances beyond your control such as hospitalization, death or illness of a family member, auto accident in transit to your appointment and hazardous driving conditions. We do reserve the right to require documentation supporting your reason.

PATIENT COPY – PLEASE KEEP FOR YOUR RECORDS



Note this is a NPP that reflects Omnibus changes as of March 2013

Gastro Health (Formerly Gastro-Intestinal Associates, Inc.)

NOTICE OF PRIVACY PRACTICES

Effective Date: 9/19/2013

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: Patricia Schnipke
Phone Number: (419) 227-8209 ext: 100

Section A: Who Will Follow This Notice?

This Notice describes Gastro Health (Formerly Gastro-Intestinal Associates, Inc.) (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

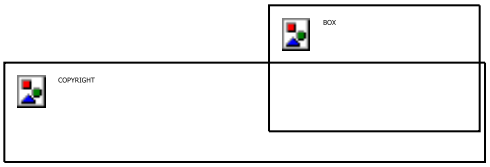
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Provider. We need this record to provide you with quality care and to comply with certain legal requirements. 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 from other 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 identity.

- **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.

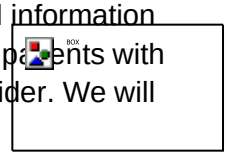
- **Communication Barriers.** We may use and disclose your health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

- **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 research 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.
- **E-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.

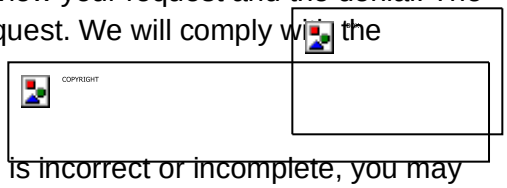
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health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

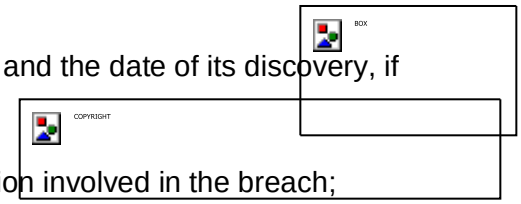
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved 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.

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.

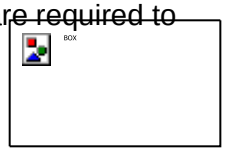
Section G: Complaints

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.