Patient: ______________________

PATIENT INFORMATION FORM

Today's Date: ______________ **Who referred you to our office?** ______________

PATIENT INFORMATION

Title: __________ **SSN:** ______________ **Sex:** M ☐ F ☐

Last Name: ______________ **First Name:** ______________ **M.I.:** ______

Street Address: ______________________________

City: ______________ **State:** ______ **ZIP:** ______

Date of Birth: ______________ **Age:** ____ **Driver's Lic#:** __________ **State:** ______

Home Phone: ______________

Work Phone: ______________

Cell Phone: ______________

Email: ______________

EMPLOYER INFORMATION

Employer: ______________

City: ______________

State: ______________ **ZIP:** ______

Emp. Phone: ______________ **Ext.:** ______

Marital Status: M ☐ S ☐ D ☐ W ☐ **Spouse's Name:** ______________

Emer. Contact: ______________ **Relation:** __________ **Phone:** __________

Emer. Contact: ______________ **Relation:** __________ **Phone:** __________

INSURANCE PLAN/CARRIER

Insurance Co.: ______________ **Effective Date:** __________

Plan Number: ______________ **Insured's Name:** ______________

Policy #: __________ **Group #:** __________ **Insured Patient's #:** __________

Patient's relationship to insured: ______________ **Annual Deductible:** __________

Insurance Co.: ______________ **Effective Date:** __________

Plan Number: ______________ **Insured's Name:** ______________

Policy #: __________ **Group #:** __________ **Insured Patient's #:** __________

PAYMENT IS EXPECTED ON THE DATE OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. I authorize Dr. Enayati to bill my insurance company and / or Medicare and assign benefits payable to him. I understand that some services (even necessary, routine or preventative measures) may or may not be covered by my policy and that I will be financially responsible for these services if deemed unpayable by my insurance carrier. Should my insurance company fail to pay within 90 days for any reason, I will assume full responsibility for any outstanding balance.

PATIENT OR RESPONSIBLE PARTY SIGNATURE

X ______________________________ ______________

Customer Name Date

Patient: ______________________________

MEDICAL HISTORY FORM

List All Your Medications:

	Medication	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Medication Allergies

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________

Past Medical History:

Please place a check mark if you or your family have ever had any of the following:

1. Diabetes	You ☐	Family ☐	6. Psychiatric Problem	You ☐	Family ☐	11. Heart Disease	You ☐	Family ☐
2. Thyroid	You ☐	Family ☐	7. High Blood Pressure	You ☐	Family ☐	12. Liver Function	You ☐	Family ☐
3. Seizures	You ☐	Family ☐	8. Lung Disease	You ☐	Family ☐	13. Kidney Disease	You ☐	Family ☐
4. T/B	You ☐	Family ☐	9. Kidney Stones	You ☐	Family ☐	14. Urine Infection	You ☐	Family ☐
5. Cancer	You ☐	Family ☐	10. Bleeding Problems	You ☐	Family ☐	15. Infertility	You ☐	Family ☐
						16. Anesthesia Problems	You ☐	Family ☐

Type of cancer? ______________________________

Past Gynecological History:

1. Last Menstrual Period __________
2. # of Pregnancies __________
3. Live Births __________

Post Surgical History:

	Surgery	Date		Surgery	Date
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Family Medical History:

				Disease or Cause of Death
1. Father	Age ____	Living ☐	Deceased ☐	
2. Mother	Age ____	Living ☐	Deceased ☐	
3. Brother	Age ____	Living ☐	Deceased ☐	
4. Brother	Age ____	Living ☐	Deceased ☐	
5. Sister	Age ____	Living ☐	Deceased ☐	
6. Sister	Age ____	Living ☐	Deceased ☐	

Social History:

☐ Single ☐ Married | Sleep hrs./night

☐ Divorced ☐ Widowed | __________

Religion: ______________________

Race: ______________________

Ethnicity: ______________________

Language: ______________________

Occupation: ______________________

Now or Ever:

Tobacco? ________ How much?________

Coffee? ________ How much?________

Immunizations:

Last Tetanus Shot? ______________ Pneumonia Vaccine? ______________ Flu Shot? ______________

Patient: ______________________________

Do you have problems with any of the following?

(check those you have)

General:
☐ Change in Weight ☐ Fever

Skin:
☐ Lumps or Nodules ☐ Breast Lump ☐ Rashes ☐ Sores ☐ Other Skin Problems

Eyes:
☐ Glaucoma ☐ Cataracts ☐ Glasses ☐ Other Eye Problems

ENT:
☐ Trouble Swallowing ☐ Nose Bleeds ☐ Dentures ☐ Sinus Problems ☐ Earaches

Hemo/Lymph:
☐ Swollen Nodes or Glands ☐ Bleeding Problems ☐ Anemia ☐ Other Blood Disorders

Cardio/Vascular:
☐ Irregular Heart Beat ☐ Heart Failure ☐ Angina ☐ Heart Valve Problem ☐ Heart Murmur
☐ Pain in Legs with Exertion ☐ Chest Pain ☐ Phebitis ☐ Swelling in Legs ☐ Blood Clots
☐ Other Heart/Blood Vessel Problems

Respiratory:
☐ Shortness of breath ☐ Wheezing ☐ Cough ☐ Asthma ☐ Other Lung Problems

G/I:
☐ Gall Bladder Problems ☐ Blood in Stool ☐ Diarrhea ☐ Dark Tarry Stools ☐ Intestinal Bleeding
☐ Poor Appetite ☐ Hiatal Hernia ☐ Ulcer ☐ Indigestions ☐ Hemorrhoids
☐ Constipation ☐ Vomiting ☐ Nausea ☐ Hernia

Neuro:
☐ Loss of Consciousness ☐ Headaches ☐ Strokes ☐ Dizziness ☐ Paralysis
☐ Numbness ☐ Weakness

G/U System:
☐ Pain or burning with urination ☐ Kidney Stone ☐ Slow or Small Stream ☐ Blood in the Urine ☐ Frequency
☐ Getting up at Night to Urinate ☐ Leaking of Urine ☐ Poor Bladder Emptying ☐ Recurrent Urine Infections ☐ Urgency
☐ Abnormal Vaginal Bleeding ☐ Sexual Problem ☐ Menstrual Problem

Psych:
☐ Other Psychological Problems ☐ Depression ☐ Anxiety

Musculoskeletal:
☐ Joint Replacement Surgery ☐ Broken Bones ☐ Gout ☐ Arthritis ☐ Bone or Joint Pain

Endocrine:
☐ Heat or Cold Intolerance ☐ Hot Flashes ☐ Flushing ☐ Abnormally Thirsty ☐ Changes in Body Hair
☐ Skin Pigmentation Changes

Do you have any other problems you'd like to discuss with the doctor? ☐ YES ☐ NO

Please sign below indicating that you confirm the accuracy of the information you have provided.

SIGNED: ______________________________ **Date:** ______________

PRINT NAME: ______________________________

John Enayati, MD MPH
CENTURY
WELLNESS CENTER

Patient: ______________________________

OFFICE POLICIES & AGREEMENT

Notice of Privacy Practices

By signing this agreement you acknowledge that you have been presented with our **Notice of Privacy Practices**, which are attached to this agreement (also posted in reception area).

Responsibilities as a Patient

- Ask questions when you don't understand any part of your medical care.
- Cooperate with the planned treatment program or explain why cooperation is not possible.
- Communicate with us any special needs you may have or if you need anything while waiting.
- Keep scheduled appointments or call to cancel on time (see cancellation/no-show policy).
- Update personal information and insurance information whenever there is a change.
- Update your doctor with any new medical condition & complete Medication List with each visit.

How We May Communicate with You

- We may contact you regarding appointments, test results and other matters related to your healthcare, at any of the Addresses, Fax, and/or Phone numbers that you have provided on the **Patient Information Form**.
- You hereby agree to notify us of any change of address or other contact information as soon as possible.

How You May Communicate with Our Office

- You may communicate with us by Phone, Fax, or Mail.
- Using email to communicate with the doctor is reserved for Concierge patietients, only. Please let the doctor or his staff know if you are interested in this level of service.
- Please DO NOT use Email, Mail or Fax for ANY urgent matters.
- Our intention is to respond to all of our patient inquiries. If you have left a message, sent a fax, or mailed and have not received a response in a reasonable amount of time, PLEASE ... call us to make sure that we know you need to reach us.

Policy for Communicating Test Results to You

- As a patient, I agree to actively participate & communicate with this office to obtain my test results.
- As a patient, I agree to call this office 10 working days after I have completed a test if I have not been contacted. We encourage this policy to ensure there has not been a missed communication.
- After review, your doctor may recommend an "Office Visit" or a "Phone Visit" to review results & plans with you, in person.
- If we receive abnormal test results ordered by another physician, we believe that physician should counsel you directly about those results. However, you may request additional counseling from **Dr. Enayati** by scheduling an Office Visit.
- We encourage you to access the **Patient Portal** and **Healow** mobile app to view your labs and medication lists 24/7. If you have difficulty accessing your Patient Portal account, please contact access@caring.md with your full name and a number where we can reach you.

No Show & Cancellation Policy

- Please call our office **24 hours prior** to a scheduled appointment if you need to change or cancel it.
- For Monday appointments, our office should be notified no later than Friday noontime.
- We reserve the right to charge a **$50 fee** if you miss your appointment or do not cancel it in a timely fashion, and a **$75 fee** for a missed specialty testing appointment.

Proof of Identity

- Patients are required to show proof of identity (e.g. Drivers License, Passport...etc)
- I consent to having my picture taken for office records.

Policy for Patients Less than 18 Years of Age

- Proof of identity of the child should be provided at the time of first visit (school ID, birth certificate, etc.).
- Child must be accompanied by a parent or guardians during each visit and for all tests and procedures performed in or out of the office.
- If the Parent is the subscriber to insurance and is requesting that our office submit insurance claims, then the subscriber must also provide proof of identity.

Waiting Room Etiquette

- Please arrive on time and inform our staff of your arrival.
- If you arrive late we may ask you to reschedule.
- While we strive to see every patient at the time of his/her appointment, emergencies and other circumstances beyond our control may delay your appointment. The office staff will do its best to estimate your appointment time given these circumstances.
- Please be understanding when your appointment is delayed—allow flexibility in your schedule.
- If you are unable to wait, please notify the scheduler to find you a prompt appointment acceptable to you.
- Maintain confidentiality and privacy of other patients and healthcare providers.
- Please be courteous to our staff and other patients.
- Please step into the hall for all phone calls and, keep ringers and vibration turned off within our office.

Medication Refills

- As a patient, I understand that my medication refills are subject to my physician's periodic review of my health status, to assess need and to monitor therapy.
- As a patient, I must maintain my status as an "Active" patient by visiting the physician at least once a year in order for to be eligible for any prescription refill(s).
- The physician may require evaluating you in the office prior to authorizing a prescription refill.
- Some prescriptions, by law, can only be refilled with a paper prescription and cannot be digitally transmitted to a pharmacy. Please make arrangement with our office, far enough in advance to cover your needs.
- As a patient, I agree to promptly make a follow-up Office Visit when I am notified of this requirement.

Pregnancy and Medications

- As a patient, should I become pregnant, I agree to promptly notify this office, and any other treating physician, if I am taking any medications that this medical practice has prescribed.
- I also agree to discuss with my physician(s) if I am planning to become pregnant.

Doctor-Patient Relationship

- The patient or the doctor can terminate this agreement without providing an explanation.
- You understand and agree that you are not a patient of Dr. Enayati or his PAs until one of them has examined you.
- You understand that you will not be examined by Dr. Enayati, one of his PAs or be accepted as a patient in his practice until you have signed the separate Patient-Physician Arbitration Agreement.
- If you choose to terminate, please send us a letter stating that you no longer wish to be a patient. If you send us a termination letter, we will honor your courtesy by giving you a digital copy of your medical records without charge.
- If the doctor decides to terminate, he/she will provide you in writing with at least 30 days of emergency treatment & prescriptions and the final date that he/she will be available for you.
- Upon receiving a termination letter, you should act promptly to find another doctor.
- During your appointment you may be seen by Dr. Enayati or his Physician Assistant. If you have a preference, this must be specified at the time you schedule your appointment.
- You may be seen by either Dr. Enayati or one of his PAs during your visit. Please let us know if you have a prefernce at the time of scheduling.

Treatment Authorization

- I hereby authorize the physician and/or physician assistant at **Century Wellness Center** to administer such treatment and medication as may be deemed necessary or advisable in the treatment and diagnosis of my condition. I give this authorization voluntarily and I hereby acknowledge that no guarantees have been made to me as to the results of treatments and examinations.
- If the patient is a minor or legally incapacitated, the parent and/or Legal Guardian agrees that he/she has the legal authority to authorize **Century Wellness Center** to evaluate and treat the patient.

Patient: ______________________________

OFFICE POLICIES & AGREEMENT

Fees for Additional Services ("Personal Services," Generally not Covered by Insurance)

- **Telephone Visits:** Pre-arranged just like any other appointment. May be requested by patient, but requires physician's approval. Fee will be based on elapsed time, or may be set prior to the visit. Secure payment in-advance is required. Ask for details when ready to make one. Costs are generally between $100-$150. After 30 minutes, every fifteen minutes will result in a $75 charge.
- **Report Preparation:** Reports will be charged at the rate of $75 per form plus the cost of an office visit. Payment is due when the report is ready. Advance payment or a method of payment guarantee is required. Examples of Reports:
  - School, Immigration, Airlines, Health Clubs ... etc.
  - Life & Health Insurance, Disability Reports, Medical-Legal reports... etc
  - Exemption from Jury Duty (when there is a medical reason)
- **Obtaining Prior Authorization for Specific Test or Treatment:** You may request this when there are circumstances that require additional information to be provided to your insurance carrier to obtain an authorization. An example is entering an appeal process for a denied test or treatment. The physician will charge a fee based on the amount of time that is required to support your case.

Elements of Costs Associated with Procedures & Services

Medical billing is very complex. We urge you to ask questions before making assumptions.

- **Billing Questions:** Please contact our billing department at **862-225-9925** or **862-225-9926**
- **Insurance Questions:** All questions pertaining to your insurance coverage should be addressed with your medical insurance company.

Copying Policy

- Patients have self-serve access to their records through our Patient Portal. If you need help gaining access please email us at access@caring.md. There is no charge for you to obtain your records in this way.
- Should you need our staff to prepare a copy of your entire file or a portion of your records there is a Flat Fee of $75, plus postage (Priority Mail or similar). Preparing a Paper Copy may cost more. We will advise you of that cost.
- There is no fee for a one time copying of pertinent records to another physician upon written request.

Testing Equipment Policy

- As needed, we may provide you with specific medical testing equipment to take home. You agree to return this equipment at the date specified. This is important as we may need it on that date for another patient.
- Failure to return this equipment on the specified date will result in fees ranging from $100-$200 for each day the equipment is returned late.
- You agree to contact our office immediately should you experience any problems with the equipment we provide you with.

Century Wellness Center and Insurance Companies

- **Century Wellness Center** has agreements with **some** health insurance companies providing PPO, with Medicare and Medicaid. It is the patient's responsibility to confirm the extent to which they are covered with their insurance provider. All uninsured patients are required to pay directly at the time of service(s). For patients with insurance contracted with Dr. Enayati, payment of the specified co-payment is required at the time of service.
- Fees and/or co-pays for imaging services and lab fees will be billed separately by those medical services. You agree to contact those businesses individually regarding any billing questions or concerns.
- When applicable, we will provide you with Payment Options after the doctor determines the services you need & we understand your insurance benefits.

Financial Obligations & Assignment of Benefits

- As a patient, I agree to pay for all medical services, insurance deductibles, co-payments, co-insurance or any prior unpaid balance Prior to or at the Time of Service.
- I understand that I am financially responsible for all the charges whether or not they are paid by insurance.
- I agree to pay any balance upon receipt of my First Statement.
- I understand that this **Century Wellness Center** requires Advance Payment for certain in-office or out-patient services.
- I understand, I am required to be familiar with my insurance coverage and its policies and know my co-pay, co-insurance, deductible, total out of pocket expense, effective date of coverage, any pre-existing conditions, AND whether I am receiving service from a contracted or out-of-network physician or other healthcare provider / facility.
- I hereby authorize my Insurance Company to pay **Century Wellness Center**, directly. I also authorize **Century Wellness Center** to submit appeals on my behalf.
- Certain health insurance companies may require additional authorization for services and procedures, for which you may be required to sign an agreement at the time of your appointment.
- If I have an open balance, **Century Wellness Center** has the option to charge my credit card on file per the Financial Policy.
- If I have an open balance and I receive a check from my insurance, I agree to immediately endorse the back of the check to **"Ali John Enayati, MD, MPH"** & send it to our office at 2080 Century Park East, Suite 1806, Los Angeles, CA 90067.
- I hereby authorize the release of all necessary information to secure the payment of benefits.
- If for any reason any portion of the bill is not paid by my insurance within thirty days of when the claim was submitted, I agree to contact my insurance company and make arrangements for prompt payment.
- For returned checks, we will apply an additional fee of $30.00.
- Late fees and other charges may apply if payments are not received in a timely manner.
- A copy of this agreement is deemed as valid as the original.

Release of Medical Information to and by Century Wellness Center

- I hereby authorize any prior or present treating physician, hospital or other health institution, to release all of my medical information for the purpose of Treatment and Healthcare Operations, by any means of communication, to Century Wellness Center, and authorize Century Wellness Center to use and disclose protected health information (PHI) to carry out Treatment, Payment, and Healthcare Operations. You are also required to complete our records release form.

Please sign below, indicating that you have read, understood, and agree to the terms of our office policies.

SIGNED: ______________________________ **Date:** ____________________

PRINT NAME: ______________________________

Got Questions?

Please call us if you have any questions about this policy: 310.551.1711

Patient: ______________________________

FINANCIAL AGREEMENT

Thank you for choosing Dr. John Enayati as one of your health care providers. We are pleased to be able to render services in the evaluation and treatment of your condition.

We need a current copy of your insurance card in order to bill your insurance directly for the charges and services rendered. If you are unable to provide us with a current insurance card or do not have insurance, full payment is due at the time of service. We will submit your claims to your insurance as a courtesy and we will assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Please understand that you will be financially responsible for charges that are not covered by your insurance. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If we are not contracted with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determination of rates.

If you do not have insurance, payment is due in full at the time of service.

Payment for those known, patient due amounts (co-payments, deductibles, non-covered services) is due at the time of service. Full payment for any known outstanding balance may also be due at the time of your visit. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. All other payments are expected within 60 days of receipt of our billing statement.

We are committed to providing the best diagnosis and highest quality of treatment possible for our patients. Our fees for services rendered are usual and customary for our geographic area.

If you have any questions regarding your financial account with our office, please contact our billing department at **862-225-9925** or **862-225-9926**.

SELF PAY

We expect full payment at the time of service unless prior arrangements have been made.

MEDICARE

We accept Medicare assignment. There are some services and supplies that are not covered by Medicare. We will advise you if there are any non-covered charges prior to that service being provided.

PPO

We are providers for many insurance plans, but are not all plans. **You are responsible for verifying that we are providers for your plan.** If you are a PPO member, you are responsible for co-payments, deductibles, and co-insurance at the time of treatment. Please confirm with your insurance that we are providers covered under your plan. If there are changes to your insurance eligibility, it is your responsibility to make sure we have your new insurance information or your services will be your responsibility. Co-payments and deductibles are determined by your plan and are not something we can negotiate.

HOSPITAL AND SURGERY CENTER CHARGES

In the event that you undergo surgery in a hospital or outpatient surgery center, separate charges will be made by the facility.

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges not covered by my insurance. I guarantee that the balance will be paid by cash, check, or credit card. Past due balances may be subject to additional fees.

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed in a timely manner, to ensure that payment for services rendered. I understand that I am ultimately responsible for payment of all services.

CREDIT CARD AUTHORIZATION

Our office requires that a credit card be kept on file for payment of any co-payment, co-insurance, deductible, or charge that may not be covered by your health insurance in the event of delinquency. This form will be kept confidential and only authorized staff has access to the information. If a bill goes unpaid after 60 days from the original billing date, and payment arrangements have not been agreed to, the balance on the account will be charged to the credit card on file.

I acknowledge and authorize Dr. John Enayati to charge the credit card on file, for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider. I acknowledge that my card will be run in the event payment is not received within 30 days after I receive statements. I agree to receive billing statements, invoices and receipts via the street address and/or email I have provided to this office. If I am an uninsured patient I authorize payment at time of service. I agree to update any information regarding this credit card account.

Please sign below, indicating that you have read, understood, and agree to the terms of our financial policies.

SIGNED: ______________________________ **Date:** ______________

PRINT NAME: ______________________________

Got Questions?

Please call us if you have any questions about this policy: 310.551.1711

NOTICE OF PRIVACY PRACTICES

Provided to patients in compliance with HIPAA

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: *A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: *We use health information about you to manage your treatment and services.*

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

For further information on our HIPAA compliant privacy practices please contact us at privacy@caring.md