ENTrusting LLC

Ear, Nose, & Throat Surgical Specialist

PATIENT INFORMATION

First Name: _____ Middle: _____ Last Name: _____

Preferred Name: _____ Sex: _____

Address: _____ Date of Birth: _____/ _____/ _____

City: _____ State: _____ Zip: _____ Email Addres: _____

Social Security: _____ Cell Phone: ( ) _____

[ ] Married [ ] Single [ ] Widowed [ ] Divorced Home Phone: ( ) _____

[ ] Legally Separated [ ] Domestic Partner Pharmacy Phone: ( ) _____

[ ] Employed [ ] Retired [ ] Full-Time Student Pharmacy Address: _____

Employer: _____ Primary Physician: _____

Address: _____ Primary Physician Phone: ( ) _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

To know more about our patients, we would appreciate the following information:

Preferred Language (if other than English): _____

Race: [ ] American Indian/Alaska Native [ ] Asian [ ] White [ ] Black/African American [ ] Pacific Islander

[ ] Other _____ [ ] Declined to state

Ethnicity: [ ] Not Hispanic/Latino [ ] Hispanic/Latino [ ] Declined to state

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INSURANCE INFORMATION (Please provide your insurance card to the receptionist)

Insurance Company: _____ Insured DOB: _____/ _____/ _____

Insurance/Card Holder's Name: _____ Relationship: _____

ID#: _____ Group#: _____ Phone: ( ) _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Insured DOB: _____/ _____/ _____

Insurance/Card Holder's Name: _____ Relationship: _____

ID: _____ Group #: _____ Phone: ( ) _____

Patient or Guardian Signature: _____ **Date**: _____

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PAST MEDICAL HISTORY

Have you ever been hospitalized? [ ] Yes [ ] No If yes, for what reason? _____

Have you ever been vaccinated for Hepatitis A or B (circle one)? [ ] Yes [ ] No

Have you ever been tested for Hepatitis A, B, or C (circle one)? [ ] Yes [ ] No

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Please check all that apply:

[ ] AIDS, HIV
[ ] Allergies
[ ] Anemia
[ ] Arthritis
[ ] Asthma
[ ] Back Problem
[ ] Cancer. What type? _____
[ ] Diabetes
[ ] Emphysema, COPD
[ ] Epilepsy, seizures
[ ] Glaucoma, Eye
[ ] Headache
[ ] Heart Attack
[ ] Hepatitis
[ ] Herpes
[ ] High Blood Pressure
[ ] Kidney Problems/UTI
[ ] Liver Disease
[ ] Nervous/Anxiety
[ ] Pacemaker
[ ] Psychiatric Care
[ ] Reflux Disease, Acid
[ ] Sinus Problems
[ ] Skin Rash
[ ] Stroke
[ ] Swelling of Feet
[ ] Hyperthyroid
[ ] Hypothyroid
[ ] Tonsillitis
[ ] Ulcer, Colitis
[ ] Lupus
[ ] Rheumatoid
[ ] Fibromyalgia
[ ] Depression
[ ] Other _____
[ ] Other _____

ALLERGIES: Please list any medication allergies you have: _____

_____

_____

Please list any SURGERIES you have had in your past: _____

_____

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MEDICATIONS

Drug Name	Dosage

Social History

Do you smoke? [ ] Yes [ ] No Packs per day? _____ Have you smoked in the past? [ ] Yes [ ] No

Do you chew tobacco? [ ] Yes [ ] No Have you in the past? [ ] Yes [ ] No

Do you drink alcohol, beer, wine, spirits? [ ] Yes [ ] No Drinks per week? _____ Drink in the past? [ ] Yes [ ] No

Do you drink coffee or caffeinated beverages? [ ] Yes [ ] No How many cups, cans, glasses per day? _____

Do you take any illicit drugs? [ ] Yes [ ] No If yes, what kind? _____

Are you currently taking any NSAID? [ ] Yes [ ] No If yes, what type? _____

Family History

Member	Living?	Age	Please list serious illnesses
Mother	[ ] Yes [ ] No		
Father	[ ] Yes [ ] No		
Sister(s)	[ ] Yes [ ] No		
Brother(s)	[ ] Yes [ ] No		

Has anyone in your family had any of the following:

Condition	Which Family Member?
Anemia or blood disorder/clotting disorders	
Cancer – What kind?	
Diabetes	
Genetic disorder of any kind	
Glaucoma, eye disorder	
Heart Disease	
High blood pressure	
HIV, Infectious disease	
Mental Issues, Depression, Anxiety, Bipolar	
Stroke	
Rheumatoid, lupus, rheumatological disease	

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FINANCIAL RESPONSIBILITY

This is an agreement between ENTrusting, LLC, as a creditor, and the Patient/Debtor named on this form.

In this agreement, the words "I", "you", "your", and "yours" mean the Patient/Debtor. The word "account" means any account that has been established in your name to which charges are made, and payments are credited. The words "we", "us", and "our" refer to ENTrusting, LLC.

_____**Initials** Insurance: ENTrusting, LLC participates in many different types of health insurance plan that may vary in the amount and extent of coverage and medical services provided. It is your responsibility to check with your insurance to verify that Dr. H. Van Nguyen is within your network and your medical services will be covered. If you are unable to show proof of coverage or do not have health insurance, your appointment will be rescheduled, or you will be required to pay for services the day of your appointment. You are also responsible for knowing your insurance benefits and coverage. We will gladly file your insurance claim on your behalf with the insurance companies that we participate with and will allow 45 days for them to process the claim. If your insurance company does not process the claims within that period of time, you will be responsible for paying the entire bill. If there should be a dispute between you and your insurance company regarding coverage and/or policy benefit criteria such as co-pays, deductibles, co-insurance, non-covered services, and benefits coordination, we will not become involved. You are responsible for all co-payments at the time of your service.

_____**Initials** Missed Appointment Fee: I understand that *Appointment Reminders are a courtesy*. Failure to show up for, or cancellation of an appointment with less than 24 hours' notice may result in a no-show fee assessed to my account. The no show fee will be $25 and must be paid in full before a new appointment is scheduled. Patients with three missed appointments may be discharged from ENTrusting, LLC.

Guarantee of Payment

For value received, including but not limited to the services rendered, I agree to guarantee and promise to pay ENTrusting, LLC all charges and expenses incurred in my treatment, unless otherwise agreed in writing that these charges will be discharged by ENTrusting, LLC. I understand and agree that if ENTrusting, LLC is required to bring a claim or file an action to enforce this agreement, ENTrusting, LLC shall be entitled to recover from me its reasonable attorney's fees, expert fees, courts costs, and any other costs of collection, in addition to the amount owned to ENTrusting, LLC for its services.

Returned Checks

A returned check will result in a service fee based on the face value of the check and may require all future payments to be made by cash or credit card. A collection agency may be used in the recovery of debt attributed to returned checks, in addition to the payment of the check plus any court cost, reasonable attorney fees, and any bank fees incurred by the payee in taking action as pursuant to *Florida Statute 68.065.*

Divorce, Dependent and Child Custody Cases

Regarding divorce, the presenting guardian accompanying the person (minor or disabled adult) who receives care at ENTrusting, LLC is responsible for payments of copays, co-insurance and/or deductibles at the time of service.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by ENTrusting, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of ENTrusting, LLC. I understand that diagnosis or treatment to me by ENTrusting, LLC may be conditioned upon my consent as evidenced by my signature on this document.

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My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the ENTrusting, LLC *Notice of Privacy Practices* prior to signing this document. ENTrusting, LLC's *Notice of Privacy Practices* has been provided to me. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of ENTrusting, LLC. The *Notice of Privacy Practices* also describes my right and the duties of ENTrusting, LLC with respect to my protected health information. ENTrusting, LLC reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*.

LIFETIME AUTHORIZATION

By signing below, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent or this physician or supplier, any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. The original authorization will be kept on file by ENTrusting, LLC.

I may obtain a revised Notice of Privacy Practices by requesting in writing from ENTrusting, LLC.

Patient/Guarantor (Print): _____

Patient/Guarantor (Signature): _____ Date: _____

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AUTHORIZATION TO COMMUNICATE PROTECTED HEALTH INFORMATION (PHI) via ELECTRONIC MEANS

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

DOB: _____/ _____/ _____ Phone #: ( ) _____

I AUTHORIZE ENTRUSTING, LLC TO COMMUNICATE WITH ME VIA THE FOLLOWING ELECTRONIC MEANS:

METHOD	CONTACT INFORMATION
[ ] TEXT	
[ ] EMAIL	
[ ] VIDEO CONFERENCE	
[ ] PHONE CALL	
[ ] VOICE MAIL	

[ ] I do not authorize ENTrusting, LLC to communicate with me via electronic means.

This Authorization to Communicate PHI via electronic means expires:

[ ] Upon written revocation [ ] Other

1. I understand that by selecting the method of communication above and signing below, I authorize ENTrusting, LLC to share/communicate PHI information via electronic means to myself or my designated representative described above.

2. I understand ENTrusting, LLC may communicate to me information such as, but not limited to, when I have an upcoming appointment, upcoming procedure, services recommended by my doctor, medication refills, test results, new services offered, financial information or statements and new locations at ENTrusting, LLC.

3. I understand that according to HIPAA Privacy Rule §164.501, ENTrusting, LLC cannot sell or distribute my communication method or information with any third-party without my prior consent.

4. I understand that, by federal law, ENTrusting, LLC may not use or disclose my health without my authorization, except as provided in ENTrusting LLC's Notice of Privacy Practices.

5. I hereby release ENTrusting, LLC and its employees from any and all liability that may arise from the release of information as I have directed.

6. I understand emailing and texting are not secure forms of communication and I release ENTrusting, LLC from any liability.

7. I understand that I have the right to revoke this Authorization at any time, if I do so, it must be in writing and address to ENTrusting, LLC. The revocation will not apply to any information already released as a result of this authorization.

8. I understand that I may refuse to sign this Authorization to communicate PHI via electronic means and that I cannot be denied or refused treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign it.

Notice of Billing Efforts Conducted via Electronic Means

I understand that in its regular course of billing and collection efforts, ENTrusting, LLC may communicate with me via electronic means and that any phone number (including cellular phone numbers) and/or email address provided to ENTrusting, LLC may be used for these purposes. I consent to the use of email, text or automated voicemail communication by ENTrusting, LLC if I have any balances due on my account, regardless of my preferred Contact selection(s) for communication of protected health information (PHI) via electronic means. I understand that contacts may be made as a direct dial call or through the use of email, text messages, pre-recorded or artificial voice messages, and/or the use or an "automated telephone dialing system" or "autodialer". I understand that message or data rates may be assessed by my mobile provider.

By signing this form, you represent that you are the cellular subscriber or customary user with respect to the cellular number(s) provided and that you have the authority to provide consent.

Print Name: _____ Date: _____

Signature: _____

Signature by: [ ] Patient [ ] Legal Guardian [ ] Proxy [ ] Legal Representative

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HIPAA CONTACT INFORMATION

In the following section, please let us know of any person or persons that we can communicate with in regards to your care. This will enable us to let these individuals know about our test results, office visit information, and other sensitive and protected health information. You must list spouses, parents, siblings, friends, and relatives on this document for us to be able to communicate with them. We will not release copies of your medical records to these individuals without your written request to do so. You can revoke this request at any time by a written or a verbal request.

I, _____, hereby request confidential communication of my protected health information to the following individual or individuals:

Contact Person: _____ Address: _____

Phone Number: _____ Relationship: _____

Contact Person: _____ Address: _____

Phone Number: _____ Relationship: _____

Contact Person: _____ Address: _____

Phone Number: _____ Relationship: _____

Patient Signature: _____ Date: _____

ENTrusting LLC

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CONSENT TO TREAT

I, the undersigned, hereby voluntarily give my consent to ENTrusting, LLC and its healthcare providers to provide medical treatment, including but not limited to, diagnostic procedures, treatment, and medical services that are necessary or advisable for my health care.

Purpose of Treatment:

The purpose of this consent is to allow the healthcare profession at ENTrusting, LLC to provide medical care, including examination, diagnosis, treatment, and follow-up care. I understand that medical care includes, but not limited to, routine medical evaluations, diagnostic tests, and preventive care.

Nature of Treatment:

I understand that the procedure and treatments may include physical examinations, medical history reviews, laboratory testing, imaging studies, medical interventions, and other diagnostic or therapeutic services. I acknowledge that no guarantees or assurances have been made to me regarding the outcome of any procedures or treatment.

Voluntary Participation:

I understand that I am voluntarily seeking medical treatment and that I have the right to refuse or discontinue any medical treatment at any time. I understand that I will be informed of the risks and benefits of any recommended treatments and procedures.

Confidentiality of Information:

I understand that my medical records will be kept confidential, and that my information will only be disclosed as required by law, or with my written consent. I am aware that my medical records may be shared with other healthcare providers involved in my care for purposes related to my treatment.

Right to Ask Questions:

I acknowledge that I have been provided with an opportunity to ask questions about the proposed treatment and that all questions have been answered to my satisfaction.

Acknowledgement of Risks and Benefits:

I acknowledge that I have been informed of the potential risks and benefits of the proposed treatment or procedures. I have had the opportunity to discuss my concerns and have received adequate answers.

Patient Name (printed): _____ DOB: _____ Date: _____

Patient/Guardian Signature: _____ Relationship: _____

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CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Pursuant to Florida Statute Section 817.5655, a patient is entitled to provide informed consent prior to the transfer of any biological specimen. Specially, the statute mandates that before any specimen, including but not limited to blood, tissue, or other biological materials, is transferred for any purpose other than the initial medical treatment or testing, the patient must be fulling informed of the purpose, scope, and potential uses of the biological specimen.

During the course of your care with ENTrusting, LLC, and its affiliates, it may be medically necessary to obtain blood, urine, stool, tissue, or other type of biological specimen for analysis. This analysis will not involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state, and federal requirements.

It may also be the case that a biological specimen(such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing, or other objects. These objects may then be transferred to a third party for cleaning and disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with ENTrusting, LLC, and its affiliates, to a third party to set forth the above. This consent does not authorize the sales or transfer of a biological specimen for the purpose of DNA analysis.

X _____ _____

(Patient's Signature) (Date)

_____ _____

(Patient's Printed Name) (Date of Birth)

ENTrusting, LLC
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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more completed text is posted in the office.

What is this all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide with you office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additionally, information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

HIPAA Information and Consent Form

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain enforced from this time forward.

_____

Signature **Date**

Health Oversight Agency: Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

We will not use or disclose your health information without your authorization, except as described in this notice.

Other Uses and Disclosures of Your Information by Authorization Only
We are required to receive your authorization to use or disclose your PHI for any use other than treatment, payment or health care operations, and those specific circumstances outlined above. We use an Authorization to Use/Disclose form that specifically states what information will be given to whom, for what purpose, and is signed by you or your legal representative. You can revoke the signed authorization at any time by a written statement given to us to that effect.

Patient Name (Printed): _____ Date: ____ / _____ / _____

Patient/Guardian Signature: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date	Initials	Reason

ENTrusting LLC
Ear, Nose, & Throat Surgical Specialist

Florida Patient's Bill of Right and Responsibilities
Florida Statute Chapter 381(028)

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

1. A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
2. A patient has the right to a prompt and reasonable response to questions and requests.
3. A patient has the right to know who is providing medical services and who is responsible for his or her care.
4. A patient has the right to know what patient support services and available, including whether an interpreter is available if he or she does not speak English.
5. A patient has the right to know what rules and regulations apply to his or her conduct.
6. A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
7. A patient has the right to refuse any treatment, except as otherwise provided by law.
8. A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
9. A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts for Medicare assignment rate.
10. A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for the medical care.
11. A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill, and upon request, to have the charges explained.
12. A patient has the right to impartial access to medical treatment or accommodation, regardless of race, national origin, religion, handicap, or source of payment.
13. A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
14. A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
15. A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievances procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
16. A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

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Florida Patient's Bill of Right and Responsibilities
Florida Statute Chapter 381(028)

17. A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
18. A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
19. A patient is responsible for following the treatment plan recommended by the health care provider.
20. A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
21. A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
22. A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as a promptly as possible.
23. A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

ENTrusting LLC
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NOTICE OF PRIVACY PRACTICES

ENTrusting, LLC understands your privacy is important. This Privacy Notice 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 control your protected health information. **PLEASE REVIEW THIS CAREFULLY.**

Protected health information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition or payment.

Understanding Your Health Record/Information
Each time you visit our office, a record of your visit is made. Typically, this record contains personal demographic information, your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment;
- Means of communication among the many health professionals who contribute to your care;
- Legal document describing the care you received;
- Means by which you or a third party payer can verify that services billed were actually provided;
- A tool in educating health professionals;
- A source of data for medical research;
- A source of information for public health officials charged with improving the health of the nation;
- A source of data for facility planning and marketing; and
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy;
- Better understand who, what, when, where and why others may access your health information;
- Make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522. However, we are not required to agree to the restriction;

- Inspect and copy your health record as provided for in 45 CFR 164.524 and Florida law. Usually this includes medical and billing records, but does 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.
- Amend your health record as provided in 45 CFR 164.526. To request an amendment, your request must be in writing and must provide a reason that supports your request. We may deny your request if you ask to amend information that:
    - Was not created by us;
    - Is not part of the medical information kept by ENTrusting, LLC;
    - Is not part of the information which you would be permitted to inspect or copy; or
    - Is accurate or complete.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528. To request this list or accounting of disclosures, your request must be in writing and must state the time period which may not be longer than six years.
- Request communications of your health information by alternative means or;
- Receive confidential communications of protected health information as provided in 45CFR 164.522 (b), as applicable;
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Restrict the release of protected health information to your health plan if you are paying out of pocket in full. 45 CFR 164.522(a)(1)(vi).

Our Responsibilities:
ENTrusting, LLC is required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction;
- Accommodate reasonable requests you may have to communicate health information by alternative means.
- Notify affected individuals following a breach of unsecured protected health information in writing.

We will also provide a referring physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you.

We will use your health information for payment. For example, a bill may be sent to you or an insurance company (third party payer). The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

We will use your health information for regular healthcare operations. For example, in day-to-day business practices, trained staff may handle your physical medical record in order to have the record assembled or for filing reports into your record. Certain data elements are entered

into our computer system that processes most billing, schedules your appointments and for statistical reporting. As part of our improvement efforts to provide the most effective services, your record may be reviewed by professional staff to assure accuracy, completeness and organization. This information may be shared by facsimile transmission.

Other Uses or Disclosures
Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law. These programs provide benefits for work-related injuries or illness.

Public Health: As required by law, we may disclose your health information to public health or legal authorities for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births or deaths;
- 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;
- 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 when you agree or when required or authorized by law.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law:

- In response to a court order, valid 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 Clinic; 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.

Disaster Relief: We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care or notify family or friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.