Dr. Jaya Sonkar, MD (Rheumatologist)

General Consent for Evaluation and Treatment for Patients of JSR Health

TO THE PATIENT: Welcome to our practice. At this point in your care, no specific treatment plan has been recommended, until we have had the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended surgical, medical or diagnostic procedure to be used. You may then decide whether or not to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved. This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice or one that has been identified. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Acceptance:

You have read, understand, are legally able and agree to the provisions of JSR HEALTH PLLC. Patient Financial and Office policy. If this form is signed by anyone other than the patient, it is warranted that the signatory has the legal authority to do so.

Name (please print):

____**Date:**_________________

Signature of Responsible Party

(Patient/Guarantor):____

Relationship to Patient(s) (please check): ___ **Self** ___**Other:** ______________________

Instruction: Please type **S** for **Self** and **O** for **Other**
Type **Y** for **Yes**, and **N** for **No**
Type **Y** in the box for **the option to choose from 2 options**

Financial and Office Policy

Insurance:

As a courtesy, JSR HEALTH PLLC Rheumatology Clinic (We/our/us) will gladly file the forms necessary so that patients (you/your) receive the full benefits of their medical coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. If you are concerned about coverage for any of our services, **please contact your insurance company prior to your visit**. If your insurance company denies coverage, or we otherwise do not receive payment **60 days** from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we **cannot** force your insurance company to pay for the services we have provided to you.

Financial Arrangements:

Because we realize that every person's financial situation is different, we provide a variety of payment options. For your convenience, we accept all major credit cards and checks. **(Returned checks will be subject to a $35 returned check fee)**. If the check is returned for any reason, you will have 7 days to contact our office and arrange another form of payment.

Deductibles and Co-pays:

Full payment is due at the time services are rendered. This includes co-payments, deductibles and services not covered by your insurance. If you are on a high deductible plan, we collect $200 (discounted price) for new patients and $150 (discounted price) for established patients until the deductible has been met. If you are not able to pay your co-pay or deductible, you may be asked to reschedule your appointment.

Appointments/Cancellations:

We gladly reserve appointment times for you and appreciate that you have chosen JSR HEALTH PLLC Rheumatology Clinic for your care. As a courtesy, we will remind you of your appointment by calling and/or text/emailing you prior to your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full, or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment. We respect our patient's valuable time, and we request the same courtesy from our patients. Please extend this

courtesy should you need to cancel and/or reschedule your appointment. **We charge $40 for appointments canceled or not kept by you without advance notice of at least two (2) business days.**

Late Fees:

Your account becomes delinquent if not paid within 30 days after billing and the unpaid balance becomes subject to a monthly finance charge of 1.5% (18% APR) or $35, whichever is greater. Any further delinquency will warrant the balance and any administrative fees being assigned to a collection agency.

Assignment and Release:

You authorize release of any medical care information requested by your insurance company.

Prescription Refills:

We only provide prescription refills during an office visit with a physician. We require office visits on a **regular basis** for all patients taking prescription medications. Please bring all prescription bottles and a current detailed medication list with you to your appointment.

Credit Card on File Policy

JST HEALTH PLLC Rheumatology Clinic is committed to making our billing process as simple and easy as possible. We provide provisions for patients to provide a credit card on file with our office. We will scan your card with a card reader. If you choose to save the credit card on file, our third-party merchant will store your card number at a secure, compliant location. For security reasons only the last four digits will be visible to our staff. Credit cards on file will be used to pay copays when you are seen in our office, including account balances, after your insurance processes your claim.

If we do not receive payment for the amount listed on your statement within 14 days, we will run the credit card on file for the full amount owed. If your payment is declined, we will call you. If our reminder call is not returned within one week, a $35 declined payment fee will be applied, and another statement will be mailed. Your account becomes delinquent if not paid within 30 days after the date of the original statement. The unpaid balance will be subject to a finance charge of 1.5% (18% APR) or $35, whichever is greater. Further delinquency will be subject to collections with additional finance fees. You give JSR HEALTH PLLC permission to charge your credit card for any patient balance due on your account.

Dismissal:

If you are 'dismissed' from the practice it means you can no longer schedule appointments, get medication refills, or consider us to be your doctor. You must find a doctor in another practice. Common reasons for dismissal:

- failure to keep appointments, frequent no-shows
- non-compliance, which means you will not follow physician instructions about an important health issue.
- abusive to staff
- failure to pay your bill.

Dismissal Process:

We will send a letter via email and if we don't get an acknowledgement, we will mail to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to your new doctor after you let us know who your new doctor is and sign a release form.

Acceptance:

You have read, understand, are legally able and agree to the provisions of JSR HEALTH PLLC. Patient Financial and Office policy. If this form is signed by anyone other than the patient, it is warranted that the signatory has the legal authority to do so.

Name (please print):

____Date:__________________

Signature of Responsible Party

(Guarantor):____

Relationship to Patient(s) (please check): ___ Self ___Other: ______________________

Note: The patient (or Guarantor) must sign this sheet and present valid photo identification before the patient can be seen. This is for your protection and to prevent fraud.

Thank you for understanding our office policies. We are excited you chose JSR HEALTH PLLC Rheumatology clinic for your rheumatology care.

JSR Health Clinic Policies and Procedures

For your convenience, we have provided office policy information below. Some information is provided simply for your review so you may be well informed of your rights and obligations as a patient. If you have any questions or concerns regarding these policies, we will be glad to answer any questions you may have. Please call our office directly with any questions.

Appointments and Reminders

To schedule, cancel, or modify an appointment, you may call our office directly. Clinic staff are available by phone Monday-Friday, 8 a.m. - 5 p.m. Please call at least 48 hours in advance if you need to change your appointment so we can schedule another patient at that time. We ask that you arrive 15 minutes early for an office appointment to update forms as necessary. A reminder for your scheduled appointment will be provided by telephone call/text message in the days leading up to your appointment.

Referrals to Our Specialists

Some of your medical conditions may require a referral to another specialist in a particular field of medicine. If this is the case, we will refer you to a specialist, however, based on your insurance provider, you may need to see your primary care provider first and obtain the referral in which case we will inform your primary care office. Please be aware that all your medical records (not just specialty provider records) are maintained by your primary care provider who understands your medical condition along with your medical history and course of treatment. Therefore, your primary care provider can recommend what specialists would be appropriate to visit.

If referred to a specialist, your insurance plan may require referral paperwork or other authorization for visits to any of our specialty providers. Please contact your primary care provider or insurance company for more information.

What to Bring to an Appointment

You can save time at the clinic by coming prepared to your visit with the following:

- Any paperwork the office has asked you to complete prior to arriving
- Insurance card(s)
- Photo ID
- Medication bottles and supplements you are currently taking
- A list of all allergies
- A list of questions you want to ask your healthcare professional
- A list of any medications you need refilled

New Prescriptions/Prescription Refill

The following guidelines for new prescriptions and prescription refills are provided to ensure you receive quality care and service:

For medication to be effective, it should be taken exactly as your provider prescribes. It is much easier to evaluate the progress made with a medication if a patient has remained compliant with instructions.

We cannot provide a medication without an evaluation first. We only provide medications pertaining to our branch of medical specialty i.e., Rheumatology. Contact our office to schedule an appointment. If your prescription bottle indicates you have refills left, you do not need to call the office; your pharmacy will refill this for you.

It will generally take your provider 48-72 hours to contact your pharmacy when issuing a refill request. However, based on your insurance company and coverage, there can be a delay in you obtaining the medication, even after our office fill provide the necessary prior authorization paperwork. Rest assured; we will do what everything possible to get the medication approved but the timely insurance approval of the medication is not in our control.

Whenever you feel a medication is ineffective or needs adjusting, call your provider's office to schedule an appointment.

After Hours Care

During normal business hours (8 a.m. – 5 p.m.), contact your provider’s office directly. Outside of these hours, our answering service is available to direct your care. If you have a situation that necessitates contacting your provider during these off-hours, please call 832-295-9186 and if unanswered, please call our off hours answering services at 832-295-9186, your provider or a covering provider, will be notified to return your call. We try our best to answer all calls within 24 hours but it may take upto 3 business days to respond to these calls. If you have an emergency that you would consider serious or life-threatening, go directly to the Emergency Room or dial 9-1-1 for emergency assistance.

Requesting Records

When requesting copies of your medical records, please clarify if it is an urgent or non-urgent situation. We do not want your medical care to suffer even if you have decided to

move on from our practice. In an urgent situation, please allow 3 business day and in a non-urgent situation, we ask that you please allow a minimum of 15 business days to prepare your request for pick-up. Please fill out Authorization For Release of Medical Information and submit to our office either by fax (fax number 314-405-9678) or in person. If the record request was not made in person, we require you to call our office and speak with a staff member to notify us of the records request and whether it is an urgent or non-urgent.

A patient may request records for:

- Personal use (charges will apply)
- To leave your current practitioner and have your medical care transferred to a new practitioner in another clinic (charges will apply)
- When your practitioner has referred you to the care of another practitioner or specialist (no charge)

No-Show Policy

Attending regularly scheduled appointments is necessary to provide quality care. If you need to reschedule an appointment, adequate notice needs to be given.

Non-participation in treatment as exhibited by not coming to scheduled appointments or excessive cancellations is cause for terminating the provider/patient relationship and may also be subject to a fee. If you do not show or fail to cancel an appointment at least 24 hours in advance for 3 consecutive appointments or 4 appointments within a 12-month period, the provider may pursue closing your case and terminating the relationship.

Arriving Late for an Appointment

If you arrive late for an appointment, you may be asked to reschedule. Every attempt will be made to get you in to see your physician, but this will depend on the remaining patient schedule and the availability of the practitioner.

Patient Termination Policy

Although it is an infrequent occurrence, a provider/patient relationship may be terminated. Reasons for termination include, but are not limited to: use of foul language; chronic noncompliance with recommended therapy; abusive behavior of staff, practitioners, visitors or other patients; or other disruptive behavior. A patient whom is terminated will be notified of the termination and given 30 days to locate another medical office for their continued care.

Patient Feedback/Advocacy

Our clinic welcome and encourage your feedback, both positive and negative. We will assist you with the coordination, investigation, and resolution of any patient complaint regarding experience.

Privacy Policy

We are required by law to maintain the privacy of your medical information. We are also required to notify you of our legal duties and privacy practices regarding your medical information and abide by the terms of this Notice.

Acceptance:

You have read, understand, are legally able and agree to the provisions of JSR HEALTH PLLC. Patient Financial and Office policy. If this form is signed by anyone other than the patient, it is warranted that the signatory has the legal authority to do so.

Name (please print):

____**Date:**________________

Signature of Responsible Party

(Guarantor):____

Relationship to Patient(s) (please check): ___ **Self** ___**Other:** _____________________

Note: The patient (or Guarantor) must sign this sheet and present valid photo identification before the patient can be seen. This is for your protection and to prevent fraud.

Thank you for understanding our office policies. We are excited you chose JSR HEALTH PLLC Rheumatology clinic for your rheumatology care.

Dr. Jaya Sonkar, MD (Rheumatology)
21216 NW Freeway Suite 230
Cypress, TX 77429 **Phone No. 832-295-9186** **Fax No. 314-405-9678**

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize My Primary Care Physicians and Specialists to release healthcare information of the patient named above to:

Name: JSR Health PLLC and Dr. Jaya Sonkar

Address: 21216 NORTHWEST FWY STE 230

City: CYPRESS State: TEXAS Zip Code: 77429-4695

This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition, or dates: ______________________

□ All healthcare information □ Other:

____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

□ Yes □ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

□ Yes □ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Permission for Telehealth Visits

What is telehealth?

Telehealth is a way to visit with healthcare provider at JSR HEALTH

You can talk to your provider from any place, including your home. You don't go to a clinic or hospital.

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- Sometimes, you use video so you and your provider can see each other.

How does telehealth help me?

- You don't have to go to a clinic or hospital to see your provider.
- You won't risk getting sick from other people.

Can telehealth be bad for me?

- You and your provider won't be in the same room, so it may feel different than an office visit.
- Your provider may make a mistake because they cannot examine you as closely as at an office visit. (We don't know if mistakes are more common with telehealth visits.)
- Your provider may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?

- We will not record visits with your provider.

- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- There is a very small chance that someone could use technology to hear or see your telehealth visit.

What if I want an office visit, not a telehealth visit?

You can schedule an office visit now if you don't want to wish to participate in telehealth.

What if I try telehealth and don't like it?

- You can stop using telehealth any time, even during a telehealth visit.
- You can still get an office visit if you no longer want a telehealth visit. But you might have to wait for office hours.
- If you decide you do not want to use telehealth, please don't sign this form.

How much does a telehealth visit cost?

- What you pay depends on your insurance.
- A telehealth visit will not cost any more than an office visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

Do I have to sign this document?

No. Only sign this document if you want to use telehealth.

Do not sign this form until you start your first telehealth visit. Your provider will discuss it with you.

What does it mean if I sign this document?

If you sign this document, you agree that:

- We talked about the information in this document.
- We answered all your questions.
- You want a telehealth visit.

If you sign this document, we will give you a copy.

Your name (please print) Date

Your signature Date

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and

I hereby authorize JSR Health PLLC/ Dr. Jaya Sonkar to use and/or disclose the protected health information described below to

1 Authorization for Release of Information. Covering the period of health care from

☐ _______________ to _______________ **OR** ☐ all past, present and future periods:

a. ☐ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

b. ☐ I hereby **authorize the release of my complete health record with the exception of the following information**:

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): ____

2. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

3. This authorization shall be in force and effect until ____________________, at which time this authorization expires. [Date or Event]

4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

5. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

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

____ ________________________________

Signature of Patient or Personal Representative Date

____ ________________________________

Print Name of Patient or Personal Representative Relationship to Patient

NOTICE OF PRIVACY PRACTICES

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

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

JSR HEALTH PLLC is committed to protecting the privacy of medical information we create or obtain about you. This Notice tells you about the way in which we may use and disclose this information. It also describes your rights and certain obligations we have regarding the use and disclosure of your medical information. We are required by law to

1. Make sure your medical information is protected
2. Give you this Notice describing our legal duties and privacy practices
3. Follow the terms of this Notice that is currently in effect.

WHO WILL FOLLOW THIS NOTICE?

The privacy practices described in this Notice will be followed by all physicians and employees of JSR HEALTH PLLC.

WHAT IS PROTECTED HEALTH INFORMATION?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following sections describe different ways we may use and disclose your medical information. We abide by all applicable laws related to the protection of this information. Not every use or disclosure will be listed. All the ways we are permitted to use and disclose information, however, will fall within one of the following categories:

Treatment. We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

Payment. We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

Health Care Operations. We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Research and related activities. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual. Required by Law. We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

Business Associates. We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

Organ and Tissue Donation. If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation such as 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 disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work related injuries or illness.

Public Health Risks. We may disclose Protected Health Information for public health activities. This includes disclosures to:(1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Abuse, Neglect, or Domestic Violence. We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Health Oversight Activities. We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

Law Enforcement. We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

Military Activity and National Security. If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

Coroners, Medical Examiners, and Funeral Directors. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT OR OPT OUT **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care or notify family and 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 practicably can do so.

Fund-raising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fund-raising activities. You have the right to opt out of receiving fund-raising communications.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization: 1. Uses and disclosures of Protected Health Information for marketing purposes; and 2. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Office and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

Right to Inspect and Copy. You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to a Summary or Explanation. We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record. Some records may be large and may need to be arranged in compressed folders and may need a lot of staff time. Since our staff is busy helping all our patients, the office may take upto 21 days or 15 business days, which ever is later, to transfer the records.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Request Amendments. If you feel that the Protected Health Information we have, 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 us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the end of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to an Accounting of Disclosures. You have the right to ask for an “accounting of disclosures,” which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other

than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions, and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health 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. To request a restriction on who may have access to your Protected Health Information, you must submit a written request. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out of pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice, even if you have agreed to receive this notice electronically. You may request a copy of this Notice at any time.

HOW TO EXERCISE YOUR RIGHTS

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the end of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

QUESTIONS OR COMPLAINTS

You may file a complaint with us if you believe your privacy rights have been violated. To file a complaint with us, contact our officed at the address listed at the end of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint. To file a complaint with the Secretary, mail it to:

JSR HEALTH PLLC
21216 NW Fwy

Ste 230

Cypress, Tx 77429

Ph 832-295-9186

Fax 314-405-9678

Acceptance:

You have read, understand, are legally able and agree to the provisions of JSR HEALTH PLLC. Patient Financial and Office policy. If this form is signed by anyone other than the patient, it is warranted that the signatory has the legal authority to do so.

Name (please print):

____Date:_________________

Signature of Responsible Party

(Guarantor):____

Relationship to Patient(s) (please check): ___ Self ___Other: _____________________

Note: The patient (or Guarantor) must sign this sheet and present valid photo identification before the patient can be seen. This is for your protection and to prevent fraud.

Thank you for understanding our office policies. We are excited you chose JSR HEALTH PLLC Rheumatology clinic for your rheumatology care.

JSR Health Rheumatology: Notice of Privacy Practice

JSR Health PLLC

Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician’s name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.

- Signing a “Release of Information” form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your conditi ons to medications or treatment.
- Asking your clinician questions when you do not und ır illness, treatment plan or medication instructions.
- Following your clinician’s advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office’s rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

Acceptance:

You have read, understand, are legally able and agree to the provisions of JSR HEALTH PLLC. Patient Financial and Office policy. If this form is signed by anyone other than the patient, it is warranted that the signatory has the legal authority to do so.

Name (please print):

____ **Date:**_________________

Signature of Responsible Party

(Patient/Guarantor):____

Relationship to Patient(s) (please check): ___ **Self** ___**Other:** ______________________

Note: The patient (or Guarantor) must sign this sheet and present valid photo identification before the patient can be seen. This is for your protection and to prevent fraud.

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