Notice of Privacy Practices

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

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice.

New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information; and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment: We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from your insurance company or third party. Example: We may need to send your protected health information; such

as your name, address, office visit date and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations: We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization:

- As required during an investigation by law enforcement agencies
- To avert a serious threat to the public
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institutional or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations' activities (to the extent permitted under HIPAA)
- Uses and disclosures in Domestic Violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

IRIS HEALTH
MEDICAL GROUP
1-888-558-4747 | chooseirishealth.com | info@irishealthgroup.com

Photography Consent Form

Patient Name: _____ Date of Birth: _____
MRN _____

I give my permission for the Iris Health Group clinicians and staff to obtain photographs of me, my insurance cards, and other documents deemed necessary I understand that all photographs taken of me are part of my confidential medical record and will not be used or released to any other party without my written authorization. I understand I can revoke this permission at any time by submitting my request to the Iris Health Group office in writing.

_____ _____
Patient Signature Date

_____ _____
Patient's Representative Date

IRIS HEALTH
MEDICAL GROUP
1-888-558-4747 | chooseirishealth.com | info@irishealthgroup.com

Patient Consent / Acknowledgment

PATIENT NAME _____

CONSENT TO ASSESSMENT and RIGHTS AND RESPONSIBILITIES:

I/We voluntarily consent to such care encompassing medical assessment, treatment and diagnostic procedures provided by Iris Health Group and its associated providers, clinicians, and other personnel as is necessary in his/her professional judgment. I/We understand the practice of medicine is not an exact science and I/We acknowledge that no guarantees have been made as to the result of treatments or examinations.

RELEASE OF MEDICAL RECORDS:

I consent to release my hospital records and provider records to Iris Health Group will maintain a confidential medical record containing information about me and my medical condition. I authorize Iris Health Group to release copies of my medical records as necessary to other health care providers, facilities, or regulatory or accrediting bodies for the purpose of continuing and coordinating my plan of treatment, and for quality assurance, survey and accreditation purposes.

ASSIGNMENT OF MEDICAL INSURANCE BENEFITS:

I assign to Iris Health Group any medical insurance benefits payable to me for services provided by Iris Health Group and permit Iris Health Group to submit a claim for payment to Medicare or Medicaid or to other third party payors and/or any appropriate intermediary agency necessary, to bill for services provided by Iris Health Group. I choose Iris Health Group to act as my representative in claim denial appeals. Subject to applicable laws and the terms and conditions of any applicable contract between Iris Health Group and the third-party payor. I understand I am responsible for fees not reimbursed by my health insurance including but not limited to, deductibles and/or co-payments.

MEDICARE/MEDICAID PAYMENT AUTHORIZATION COVERAGE:

As a Medicare or Medicaid patient, I certify that the information I have provided in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. If Iris Health

Group believes I no longer qualify for benefits under Title XVIII and/or Title XIX of the Social Security Act, I will be notified verbally and in writing of any potential payment liability.

NOTICE OF PRIVACY:

I acknowledge that I have received the Iris Health Group Notice of Privacy Practices I understand that the Notice of Privacy Practices explains how Iris Health Group may use and disclose confidential health information that identifies me. I consent to let Iris Health Group use and disclose health information about me as described in the Notice of Privacy Practices. In doing so I am consenting to the use and disclosure of health information about substance abuse, psychiatric care, or HIV, if applicable. I consent to the release of health information about me to m insurer other third-party payors and any agents or consultants that help Iris Health Group get paid or assist in my treatment or its health care operations. I can revoke my consent in writing at any time except to the extent that Iris Health Group has already relied on my consent.

I have read this form and understand its contents at this date:

Patient or responsible party signature _____ Date: _____

Relationship to patient _____

Reason patient is unable to sign: _____

Witness Signature: _____ Date: _____

IRIS HEALTH
MEDICAL GROUP
1-888-558-4747 | chooseirishealth.com | info@irishealthgroup.com

Patient Consent for Release of Information Addition to HIPAA Notice of Privacy Practices

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment or health operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information about treatment, payment or health care operations in order to provide health care that is in your best interests.

There are times you may wish other family members or friends to inquire about your appointments or have access to your medical information. We will not release any information unless you have listed them below.

If you wish to allow messages other than just to return our calls or appointment reminders on your answering machine. Please indicate this also:

Messages:

No _____ Do not leave messages other than to "return call".

Yes _____ May leave messages.

Please list any family members or others you wish to have access to your records, for example, who may call for you, or regarding your condition. We will not release any information to spouses or your children unless they are listed here. (We will require signed releases by you from anyone wanting access to your records other than the insurance companies you have listed, healthcare provider necessary to your care, or persons listed below).

List of Names, contact number and how related:

Signature below is acknowledgement that you have received the HIPPA "NOTICE OF PRIVACY PRACTICES" which was published and became effective on this date: _____.

Printed Name: _____

Signature: _____