Bayside Internal Medicine

998 Hospitality Way, Suite 102

Aberdeen, MD 21001-1757

Phone: (410) 297-9500 Fax: (410) 297-9016

Prashant Shukla MD Karen Johnson CRNP Kortni Sorbello CRNP

Welcome Letter

Thank you for choosing Bayside Internal Medicine as your primary care site. We look forward to taking care of you.

Enclosed are new patient forms to help us enroll you with our practice. Please complete and return these forms within 5-7 days so we can obtain your medical records from your previous doctor before you are scheduled. Please complete forms in **BLACK INK** (other colors of ink do not copy well). We need these forms before your appointment to verify insurances and register you into our electronic health record. Upon receipt of your medical records, a provider will review them. You will then receive a phone call to schedule your appointment.

Please arrive 30 minutes before your appointment time with any other medical records that you have to be added to your chart. You must bring insurance cards, photo ID and any copayment required by your insurance. This allows us time to enter all of your demographics into our computer system, so that we can stay on schedule with appointments. Please bring all medications with you to every appointment.

Patients must pay copayments prior to being seen on the day of their scheduled appointment. If you do not bring your copayment on the day of your appointment, you must reschedule your appointment. For your convenience, we accept cash, checks, and all major credit cards such American Express, Discover, Master Card and Visa.

If you are unable to make your appointment, kindly give 24 hour notice to cancel the appointment. Our office will charge a $50.00 "no show fee" if the appointment is not cancelled 24 hours prior to the appointment. You will also be charged $50.00 if your appointment is missed.

If you have any questions regarding your appointment or the forms to be completed, please feel free to contact us at (410) 297-9500.

Thank you.

Patient Name: _____ DOB: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____

Middle Initial: _____ Suffix: _____

Address: _____ Apt/Other: _____

City: _____ State: _____ Zip Code: _____

Birthday: _____/_____/_____ SS #: _____ - _____ - _____

Sex (Male / Female): _____ Marital Status (S / M / D / W): _____

Home Phone: (____) _____ - _____ Cell Phone: (_____) _____ - _____

Work Phone: (____) _____ - _____ International Phone: (____) _____ - _____

Emergency Contact: _____ Emergency Phone: (____) _____ - _____

Email: _____ Referred By: _____

Race: _____ Ethnicity: _____ Primary Language: _____

PRIMARY INSURANCE

Name of Ins. Co: _____

Policy Holder: _____

Relationship: _____

Policy Holder Birthday: _____/_____/_____

Co-pay Amount: _____

Policy #: _____

Group #: _____

Policy Holder's Employer: _____

SECONDARY INSURANCE

Name of Ins. Co: _____

Policy Holder: _____

Relationship: _____

Policy Holder Birthday: ____/_____/_____

Co-pay Amount: _____

Policy #: _____

Group #: _____

Policy Holder's Employer: _____

Patient Name: _____ DOB: _____

GUARANTOR INFORMTION

Person Responsible

For Payment: _____ SS #: ___ - ___ - _____ DOB: ___/___/____

Address: _____ Apt/Other: _____

City: _____ State: _____ Zip Code: _____

Phone #: (_____) _____ - _____ Misc: _____

PATIENT AUTHORIZATION

I authorize BAYSIDE INTERNAL MEDICINE, LLC to apply for benefits on my behalf for services rendered by BAYSIDE INTERNAL MEDICINE, LLC. I request payment from my insurance company be made directly to BAYSIDE INTERNAL MEDICINE, LLC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorization to release of any necessary information including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of this primary responsibility and obligation to pay for medical services when a statement is rendered. Collectable unpaid balances will be sent to collections. The Patient or Guarantor will be responsible for collection fees as well.

_____ _____/_____/_____

Signature of Subscriber or Beneficiary Date

Patient Name: _____ DOB: _____

Bayside Internal Medicine, LLC.

I GIVE BAYSIDE INTERNAL MEDICINE, DR. SHUKLA AND STAFF PERMISSION TO SPEAK TO AND RELEASE INFORMATION TO FAMILY MEMBERS, INSURANCE COMPANIES AND ALL OTHER HEALTHCARE PROFESSIONALS REGARDING MY MEDICAL CARE, TEST RESULTS, APPOINTMENTS AND EMERGENCIES, UNLESS OTHERWISE SPECIFIED BELOW.

PATIENT SIGNATURE:_____ DATE:_____

IF THERE IS ANY FAMILY MEMBER OR HEALTHCARE PROFESSIONAL THAT YOU **DO NOT** WANT INFORMATION TO BE RELEASED TO, PLEASE LIST THEM BELOW.

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

I GIVE BAYSIDE INTERNAL MEDICINE PERMISSION TO LEAVE MESSAGES ON MY ANSWERING MACHINE REGARDING TEST RESULTS, APPOINTMENTS AND ANY OTHER MEDICAL OR BILLING ISSUE.

_____YES _____NO

PATIENT SIGNATURE:_____ DATE:_____

EMERGENCY CONTACT(S):_____

PHONE NUMBER(S):_____

HIPPA Notice of Privacy Practices

Bayside Internal Medicine, LLC

998 Hospitality Way, Suite 102

Aberdeen, MD 21001

410-297-9500

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training or medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your

protected health information to medical school students that see patients at our office. In addition, we may use a sign in-sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Used and Disclosures: Under the law, we must make disclosures to you and when required by the Security of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You make this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of our protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health not to be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it in your best interest to permit use and disclosure of your protected health information, your protected

health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy or this notice from us, upon request.

You may have the right to have your physician amend your protected health information. If we deny your request for 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 such any rebuttal.

You have the right to receive an accounting of certain disclosures we have made, of any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us to the Secretary of Health and Human Services if you believe your privacy right has been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you filing a complaint.

Crisp Participation Update

Notice of Privacy Practice Update

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care of assist providers and public health information available through CRISP by calling 1-877-952-7477 or completing and submitting an OPT-OUT form to CRISP by mail, Fax or through their website at www.crisphealth.org Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

This Notice was published and becomes effective on /before June 16, 2016.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Office in person or by phone at our main number: 410-297-9500

Acknowledgement and Receipt of HIPPA

We are required by law to maintain the privacy of, and provide individuals, with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at 410-297-9500.

Signature below is only acknowledgement that you have received this NOTICE of our Privacy Practices:

Print Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

PATIENT PORTAL USER AGREEMENT

We are pleased to provide a Patient Portal in partnership with our electronic medical records provider for the exclusive use of established patients. The Patient Portal is designed to enhance patient – physician communication. All users must be established by a previous office visit.

We strive to keep all of the information in your records correct and complete. If you identify any discrepancy in your records, you agree to notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual and correct information.

The Patient Portal provides access to the following services:

- Request appointments
- Request prescription refills
- View your medical records
- Receive educational material
- Add insurance(s) **ONLY**
- Send messages to clinical staff
- Receive health maintenance reminders
- Upload photos
- Update your personal information

The Patient Portal is not intended to provide internet based diagnostic medical services. The following limitations also apply:

• No internet based triage and treatment requests. Diagnosis can only be made and treatment rendered after the patient is **SEEN** by the Provider.

• No emergent communication or services. Any emergent conditions should be handled by calling the office directly, emergency room or calling 911 should the emergency be life threatening.

• No requests for narcotic/controlled medications will be accepted.

• No requests for new prescriptions or refills for conditions for which you are not being treated by our practice will be accepted.

• It may take 72 hours to receive a response to a message sent through the Patient Portal. If you do not receive a response within 72 hours you should contact the office at (410)297-9500.

The Patient Portal is not intended to provide internet based diagnostic medical services. The following limitations also apply:

- If you lose your password or username, you may request a new one through the Patient Portal or in person at the office by providing valid identification.
- Always remember to log out and close your browser when you are finished accessing password protected Patient Portal services. This prevents someone else from accessing your personal information.

YOU SHOULD NEVER USE A PUBLIC COMPUTER TO ACCESS THE PATIENT PORTAL.

This Patient Portal is provided as a courtesy to our patients. However, if abuse or negligent usage of the Patient Portal persists, we reserve the right, at our discretion, to terminate Patient Portal offering, suspend user access and modify services available through the Patient Portal.

That data is HIPAA compliant with high level encryption that exceeds the HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. To the extent possible, our office has undergone rigorous IT implementation and security standards exceeding industry recommendations.

Please read our HIPAA policy for information on how private health information is used in our office. All patients have signed a HIPAA agreement form. If you do not recall having signed a HIPAA agreement or need to reacquaint with the HIPAA policy, we will be happy to provide you with a copy.

Once you have signed the Patient Portal User Agreement and have provided our office with a legitimate email address that is secure, you will be given a password.

The site may be accessed by:

bayside.imscareportal.com

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of the Patient Portal and agree that I understand the risks associated with online communications between my physician and myself, and consent to the conditions outlined herein. I acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the Patient Portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I have been given an opportunity to ask questions related to this agreement and all of my questions have been answered to my satisfaction

_____

Patient Signature Date

_____

Secure / Private E-mail (Please Print Clearly)

Patient Name:_____ DOB:_____

WELCOME TO BAYSIDE INTERNAL MEDICINE. Please answer the following questions to the best of your ability before your appointment. It is confidential and will be part of your medical record. It asks for information about your family medical history. This form will give us a better understanding of your problems and will allow us to spend more time discussing treatment plans for you.

FAMILY HISTORY:

Has anyone in your family (blood related) ever been told he/she has any of the following? If yes, who was it?

Heart Attack YES NO WHO?_____BEFORE AGE 50? YES NO

Heart Diseases YES NO WHO?_____

High Blood Pressure YES NO WHO? _____

Diabetes YES NO WHO? _____

Cancer (Colon, Breast, Ovarian, Prostate, Lung etc.) YES NO WHO? _____

What Type Of Cancer? _____WHEN? _____

Bleeding Disorder YES NO WHO? _____

Stroke YES NO WHO? _____

Neuromuscular Disorders YES NO WHO? _____

Glaucoma YES NO WHO? _____

Cholesterol Issues YES NO WHO? _____

Epilepsy YES NO WHO? _____

Psychiatric Illness YES NO WHO? _____

Alcohol/Drug Problems YES NO WHO? _____

Histories Of Suicide YES NO WHO? _____

Any Other Inherited Disorder YES NO WHO? _____ WHAT?_____

Patient Name:_____ DOB:_____

Medical History:

Do you have or have had in the past, any of the problems listed below? If yes, specify:

ALLERGIES or other reactions to:

Medicines	YES	NO	_____
Foods	YES	NO	_____
Anesthesias	YES	NO	_____
Headaches	YES	NO	HOW OFTEN? _____
Anemia	YES	NO	_____
Congestive Heart Failure	YES	NO	_____
Heart Valve Replacement	YES	NO	WHEN?_____
Blood Clots	YES	NO	_____
Weight Problems	YES	NO	_____
Hepatitis	YES	NO	_____
Heart Attack	YES	NO	WHEN?_____BEFORE AGE 50? YES NO
Liver Disease	YES	NO	_____
Osteoporosis	YES	NO	_____
Peptic Ulcer Disease	YES	NO	_____
Urinary Problems	YES	NO	WHAT TYPE?_____
STD's	YES	NO	WHEN?_____
Asthma	YES	NO	_____
COPD	YES	NO	_____
Arthritis	YES	NO	_____
Brain/ Spinal Injury	YES	NO	WHEN?_____
Gout	YES	NO	_____

Patient Name:_____ DOB:_____

Medical History:

Seasonal Allergies	YES	NO	_____
Seizures	YES	NO	_____
Sleep Apnea	YES	NO	_____
Diabetes	YES	NO	_____
Stroke	YES	NO	WHEN?_____
High Cholesterol	YES	NO	_____
Depression	YES	NO	_____
Mental Illness	YES	NO	_____
Anxiety	YES	NO	_____
Irritable Bowel Syndrome	YES	NO	_____
Thyroid Problems	YES	NO	WHAT TYPE?_____
Kidney Disease	YES	NO	_____
Atrial Fibrillation	YES	NO	_____
Insomnia	YES	NO	_____
High Blood Pressure	YES	NO	_____
Reflux	YES	NO	_____
Blood Transfusion	YES	NO	_____
Cancer	YES	NO	WHAT TYPE?_____

Surgical History:

Have you ever had any surgeries? YES NO If so, please list procedure, date, Doctor and Facility

_____

_____

_____

_____

Patient Name:_____ DOB:_____

FEMALES ONLY

Menstrual Problems YES NO EXPLAIN:_____

Abnormal PAP YES NO WHEN?_____

Postmenopausal YES NO

Use Of Contraception YES NO WHAT TYPE?_____

Last Menstrual Period WHEN?_____

MALES ONLY

Prostate Problems YES NO Erectile Dysfunction YES NO

PREVENTATIVE CARE:

Have you had any of the following tests listed below? If yes, when and where?

Colonoscopy Y N Year? _____ Mammogram Y N Year? _____

DEXA Y N Year? _____ PAP / Pelvic Y N Year? _____

PSA Y N Year? _____ Eye Exam Y N Year? _____

Dental Exam Y N Year? _____

IMMUNIZATIONS:

Last Tetanus Date: _____ Last Flu Vaccine Date: _____

Last Pneumonia Date: _____ Last Zostavax (Shingles) Date: _____

SOCIAL HISTORY:

Have you ever had any reactions to anesthesia, medications or food? YES NO
If so, what type of reaction?

_____

_____

Do you work? YES NO If so, what is your occupation? _____

If not, why? _____

Patient Name:_____ DOB:_____

SOCIAL HISTORY:

Are you (please circle) Married Divorced Widowed Single Separated?

Do you live with (please circle) Spouse Family Roommate Self Other? _____

How much alcohol do you drink in one week and what type?

_____

Do you use any type of tobacco product? YES NO If so, what type? _____

How much per day and for how long? _____

Have you ever used or are currently using drugs recreationally? YES NO

What type? _____ Last used? _____

Do you have a consistent exercise program? YES NO Explain: _____

AGE SPECIFIC SAFETY MEASURES:

Do you wear a safety helmet while biking or skateboarding? YES NO

Do you wear safety belts while driving or riding in an automobile? YES NO

Do you check the status of smoke detectors in your house every 6 months? YES NO

If you own a gun, do you keep it locked and away from children? YES NO

Do you have a living will? YES NO

Please list your current daily, as needed prescriptive, non-prescriptive, vitamins, and herbs medications.

Name: _____ Use: _____ Dosage: _____

Name: _____ Use: _____ Dosage: _____

Name: _____ Use: _____ Dosage: _____

Name: _____ Use: _____ Dosage: _____

Name: _____ Use: _____ Dosage: _____

Name: _____ Use: _____ Dosage: _____

THANK YOU FOR ASSISTING US AND WELCOME TO OUR PRACTICE!

Patient Name:_____ DOB:_____

Bayside Internal Medicine Financial Policies

Insurance:

We participate with most insurance companies. You are responsible for presenting your insurance card at every visit. Changes in address, responsibility parties for billing, e-mail addresses and telephone numbers (personal and emergency) should be updated as changes occur.

Services performed in the office will be billed to your insurance unless otherwise noted that the service is not covered. In this case, we expect that payment be made at the time of service. Co-pays and deductibles are your responsibility. All co-pays are due at the time of service and deductibles will be billed to you. You are welcome to put money towards your deductible at the time of service as well. There is a billing fee of $20 if co-pays are not paid at the time of service. If you do not have insurance or your insurance card is not valid, payment is due at the time of service.

Motor Vehicle (MVA) and Workman's Compensation patients will be seen on a fee for service basis. Payments for these services are due at the time of services.

Please note that not all insurances cover all services. The patient is financially responsible for services that are not covered. It is your responsibility to know what your insurance will and will not cover.

Payment:

Our office accepts cash, check, VISA, MasterCard, Discover, and American Express. Each bounced/returned check will cost $30 due by you. All balances are due within 30 days of billing.

Collections:

Please contact our billing office to arrange monthly payments. Balances that reach 90 days will be sent to a collection agency, if your account is sent to a collection agency, you will be financially responsible. Currently, our collection agency is I.C. Systems. Their phone number is 888-735-8029. A collections fee of 30% of balance due will be added to your account. If your account goes to collections, we will temporarily terminate your relationship as a patient.

Missed Appointments:

Our office requires 24 hour notice for appointment cancellations. You will be charged a fee of $40.00 for missed appointments that are not canceled in advance. We reserve the right to discharge you as a patient if you incur three consecutive missed appointments.

Patient Name:_____ DOB:_____

Lost Referral Fee/Fax to Specialist:

Referrals will be provided to specialist. You are responsible for knowing your plans referral requirements and restrictions.

Form Completion Fee:

Due to the increasing demand for documentation, we have implemented the following policies:

1. One page forms will carry a charge of $10
2. Forms greater than one page will be charged $20
3. Letters requested for documentation of medical conditions (e.g. jury duty, letter or restrictions at work, medical clearance for athletic club, etc.) will carry a fee of $15.
4. If records need to be copied to supplement these letters, the medical record copying fee will be added.
5. Some forms require a scheduled visit (e.g. MVA medical assessments, disability, scooter forms).
6. Payment is required before the forms are released.
7. Please allow up to two weeks for forms not requiring an office visit to be completed.
8. We request that completed forms be picked up. If we are required to fax or mail your form, there will be a separate fee of $10.

Prescription Refills:

Your provider will make every effort to provide long-term prescriptions and refills during office visits. Prescriptions that need to be re-written due to lost prescription or change of a pharmacy benefit provider change will carry a fee. The re-writing of the prescriptions outside of an office visit is a courtesy. This service will carry a charge of $10 for up to 5 prescriptions and $15 for more than 5 prescriptions. This fee will need to be paid before prescriptions are released. To avoid this fee, please schedule an appointment. Controlled medications will not be refilled without an appointment.

Patient Name:_____ DOB:_____

Recording By Patients:

We respect the strict confidentiality of the physician-patient relationship, and we ask the same of you. By signing below, you agree that you will not make any recording of any person in this facility without their express written permission.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY SET FORTH BY BAYSIDE INTERNAL MEDICINE L.L.C. AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

_____ _____

Signature of Patient and/or Guardian Printed Name

_____ _____

Patient Date of Birth Date

PRIVIA MEDICAL GROUP

HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name | **Patient's Date of Birth**

Address | **Patient's Telephone Number**

City, State Zip Code | **Any Other Names Used**

I hereby request that Privia Medical Group share / disclose my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all locations):

   _____

2. Be sent to the following person / entity at the address listed below:

Bayside Internal Medicine, LLC		**Phone**: 410-297-9500
Name		
998 Hospitality Way, Suite 102		**Fax**: 410-297-9016
Address		
Aberdeen	MD	21001
City	**State**	**Zip Code**

3. I authorize disclosure of the following specific information (Include dates of service):

   _____

   _____

   _____

NOTE: UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED: ☐ YES, PLEASE DISCLOSE THIS INFORMATION: _____

4. I understand that I have the right to receive a copy of my PHI in the form and format and manner I request, if readily producible in that way, or as I may otherwise agree. **Unless I specify a specific format below, I understand that my PHI will be provided in paper format**. I hereby request that my PHI be provided in the following format: ☐ on an encrypted USB drive ☐ on an **un**encrypted USB drive ☐ on an **un**encrypted CD ☐ other (please specify) _____
5. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and would then no longer be protected by federal privacy regulations.
6. I understand I may revoke this authorization by notifying Privia Medical Group in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
7. My purpose/use of the information is for ☐ personal use; or ☐ other (please specify) _____.
8. This authorization expires on _____ ____, 20____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please specify) _____.

FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If the charges will exceed $25, we will inform you of the approximate charges <u>prior</u> to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

_____ **Signature of Patient**

_____ **Date of Patient's Signature**

_____ **Patient's Date of Birth**

_____ **If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate**

_____ **Date of Legal Guardian's/Personal Representative's Signature**

_____ **Description of Authority to Act for the Individual**

For Privia Use Only

_____	_____	_____	_____	_____	_____
Date Received	**Date Processed**	**Format**	**Fee**	**Pt Notified of Fee**	**Medical Record #**

PRIVIA
MEDICAL GROUP

Preferred Contacts

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them, such as sending correspondence to the individual's office instead of the individual's home. We invite you to share with us your preferred place and manner of communication. **You may update or change this information at any time; please do so in writing.**

Patient Name: **Date of Birth:**

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

☐ **Send all communication through my Patient Portal.**

☐ **Home Telephone:_____**
- ☐ **OK to leave message with detailed information**
- ☐ **Leave message with call-back number only**

☐ **Cell Phone:_____**
- ☐ **OK to leave message with detailed information**
- ☐ **Leave message with call-back number only**

☐ **Work Telephone:_____**
- ☐ **OK to leave message with detailed information**
- ☐ **Leave message with call-back number only**

☐ **Written Communication:_____**
- ☐ **OK to mail to my home address**
- ☐ **OK to mail to my work/office address**

☐ **Other:_____**

Preferred Contacts:
We respect your right to indicate who you prefer that we involve in your treatment or payment decisions and/or who we share your information with, including information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick-up and scheduling appointments. Please note, however, that we may share your information as set forth in our Notice of Privacy Practices to other persons as needed for your care or treatment or the payment of services we have provided. Please update this information promptly if your preferences change.

Please indicate the person(s) you prefer we share your information with below:

•Name:_____Telephone:_____Relationship:_____

•Name:_____Telephone:_____Relationship:_____

•Name:_____Telephone:_____Relationship:_____

Patient Signature: _____ Date: _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)