North Raleigh Endocrinology
6729 Falls of Neuse Rd, Ste 201
919-844-6218 (Tel)

## NOTICE OF PRIVACY POLICY

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 AND ASK ANY QUESTIONS IF YOU NEED CLARIFICATION

**Consent for Treatment**: I hereby authorize consent to examination and treatment of the patient by the provider and clinical staff and the performance of any surgical and/or diagnostic procedure that is deemed necessary during in-person office visit or virtual visit

**Authorization to Release Information**: I hereby authorize North Raleigh Endocrinology and Alvi Prime Time Clinics PLLC to release any information, including to the diagnosis and records or any treatment(s) or examination(s) rendered to me or my child to my insurance company(s) or Worker's Compensation carrier necessary to process claims. I also authorize and request my insurance company(s) to make payment of any medical benefits directly to the physician or North Raleigh Endocrinology and Alvi Prime Time Clinics PLLC. I also authorize North Raleigh Endocrinology and Alvi Prime Time Clinics PLLC to release any information including the diagnosis and records of any treatment(s) or examination(s) rendered to my child or me to specialty physicians when necessary to assist in my treatment or care. I hereby authorize North Raleigh Endocrinology and Alvi Prime Time Clinics PLLC , to review any essential labs, imaging, pathology reports, encounters or other pertinent records found in **EPIC** EMR (e.g. Duke Health Systems, UNC Health Care and related facilities, Wake Med Health, etc). I hereby authorize North Raleigh Endocrinology and Alvi Prime Time Clinics PLLC to leave a message with regard to my medical care or billing via (my) home phone, cell phone, text, email or by mail.

**Financial Responsibility**: I understand that I am responsible for payment at the time services are rendered including previous balances, copayments, coinsurance, deductibles or services not covered by my insurance plan. I acknowledge that I have provided current and accurate insurance information to enable timely reimbursement for medical services. If the insurance information cannot be verified or if I do not have health insurance coverage, I will pay in full at the time of service by credit card, cash or check. I understand that any balance after my insurance company has paid is due within 30 days of receipt of the billing statement. I understand that accounts not paid after 90 days from the date of service will be turned over to a collection agency and reported to the credit bureau. I understand that my payment is Non-refundable.

**Cancellation Policy**: I understand that if I am not able to keep a scheduled appointment. I must notify the office at least 24 hours in advance of the appointment time. I am aware that I will be charged a $50.00 cancellation fee if I do not provide 24 hours notification or do not show for a scheduled appointment (virtually or in-person office visit)

**Laboratory Tests**: I understand that, if necessary, an outside laboratory may process blood and tissue specimens taken at the time of my visit. These services will be billed separately by the lab. It is my responsibility to contact the lab with any questions or concerns regarding their bill.

**Minor Patients**: I understand that as the adult accompanying the minor, I am responsible for any payment amount due for services rendered regardless of the responsible party or insurance policyholder. I will be provided with a receipt for my personal reimbursement.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

**TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; examining you; prescribing medications and faxing them to the appropriate pharmacy to be filled.; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you have previously seen. Examples of how we use or disclose your health information for payment purposes are: asking you about your health care plan(s) or other sources of payment; preparing and sending or billing claims; and collecting unpaid amounts (either ourselves or through a

collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participating in managing care plans; defense or legal matters; business planning; and outside storage of records.

We routinely use your health information inside our office for those purposes without any obligated request of permission. If we need to disclose your health information outside of our office for these reasons, we are not obligated to ask permission.

We may ask for written permission in the following situations: forwarding any records to another facility by the facility or patient's request.

**USES AND DISCLOSURE FOR OTHER REASONS WITHOUT PERMISSION**

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations apply to us. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health purposes, such as contagious/infectious disease reporting, investigation or surveillance; and notices to and from the Federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to governmental authorities about victims or suspected abuse, neglect or domestic violence
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violators of health care laws
- Disclosures for law enforcement purposes, such as to provide information about someone who is or suspected to be a victim of a crime; to provide information about a crime at our office, or to report a crime that happened somewhere else
- Disclosure to a medical examiner to identify someone deceased or to determine the cause of demise; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations
- Uses or disclosure for health-related research
- Uses or disclosures to prevent a serious threat to health or safety
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign services.
- Disclosure of de-identified information
- Disclosures related to worker's compensation programs
- Disclosures of a "limited data set" for research, public health, or health care operations
- Incidental disclosures that are an unavoidable a by-product of permitted uses or disclosures
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information

**APPOINTMENT REMINDERS**

We may call, email or text to remind you of scheduled appointments, or that it is time to make a routine appointment.

**OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures of your health information unless you sign an authorization form. The content of an authorization form is determined by federal law. We may initiate the authorization process if the use or disclosure is assumed by our practice. You have the right to sign an authorization request for our office to prepare records for yourself or another facility. If we request that an authorization form is signed you have the right to refuse from signing, this will enable our practice from receiving records. If you sign any authorization forms you may, at any time, revoke the authorization. Revocations must be in writing.

**YOUR RIGHTS REGARDING YOUR HEALTH**

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to this, but if we agree, we must honor the restrictions that you requested. To request a restriction, you must submit a request in writing to the office contact person at the address on this notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at an alternate number rather than the main contact number, mailing your health information to a requested address rather than an address on your chart. We will accommodate your requests if within reason; there may be a fee for these services.
- Ask to see or request copies of your medical records. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site) You may be obligated to pay your fee for the medical records in advance. If your request for medical records is denied, we will send a written explanation and instructions on how to get an impartial review of our denial if one is legally available. If deemed necessary, by law we are entitled to a 30-day extension if a notice of extension has been made to the recipient.
- Ask us to amend your health information if you think that the information is incorrect or incomplete. If we agree we will amend the information within 60 days from the request. The request needs to be made in writing. It is our obligation to send the corrected information to all persons that have been authorized to receive medical records. If we do not agree, you may write a statement of your position in which will be attached to your medical records along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information we will send it along with any medical records that may be requested.
- Get a list of disclosures that we have made of your health information within the past six years. By law, the list will not include any disclosures for purposes of treatment, payment or healthcare operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one list per year without encountering a fee.
- Get additional copies of this Notice of Privacy Practices upon request or an updated version if one has been made.

**OUR NOTICE OF PRIVACY PRACTICES**

By law, we must abide by the terms of this Notice of Privacy Practices or an updated version if made. We reserve the right to change this notice at any time as allowed by law. If there are changes made to this Notice, they will be applied to any and all of your health information. If a change is made to this Notice it will be documented and/or posted.

**COMPLAINTS**

If you are concerned that we have not properly protected your health information, you are entitled to write a written complaint to our office or to notify the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint.

**FOR MORE INFORMATION**

If you want more information about our privacy practices, call or visit the North Raleigh Endocrinology and Alvi Prime Time Clinics PLLC, HIPAA Compliance Officer at the address or phone number is shown on the top of the Notice.

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## PATIENT AUTHORIZATION AND CONSENT FORM - FOR TELEMEDICINE SESSIONS

**GENERAL INFORMATION:**

- Telemedicine lets a doctor or other healthcare provider care for you, even when you cannot see him or her in person. The doctor uses the Internet or a technological tool to give you advice, perform an exam, or even do a procedure (check heart rate, etc). Telemedicine can also be used for prescription refills, book an appointment, or to let your doctor talk with other providers about your health problem or treatment.
- Before you can have a session, the telemedicine provider will decide if your health problem can be helped with telemedicine. Also, providers will be sure to have a backup plan in case of a health emergency.
- If you agree, part of your health record may be sent to the telemedicine provider before your session for their review.
- If the patient is a minor child, the telemedicine provider will explain to the parent how a telemedicine exam is different from an in-person exam. He or she will also explain if a complete evaluation of the child is possible.
- Telemedicine is more than audio-only, phone call, email, fax, or an online questionnaire.
- Sometimes you may need to come to a medical facility to use their equipment (TV screen, camera, and Internet) or for formal evaluation / thorough exam

**MORE FACTS:**

- The main goal of telemedicine is to provide you with high quality, personal health care, even though you are not seeing the provider in person.
- Before your session, you will learn about which drugs the providers can and cannot prescribe. They must follow the same laws for prescribing drugs as they would for an office visit.
- Having a telemedicine session is your choice. Even if you have agreed to the session, you can stop your medical records from being sent - if this has not happened yet. You can refuse or stop the session at any time. You can limit the physical exam.
- You will be told about all staff who will take part in the session (if any, or other than provider). You can ask that any of these people leave the room and stop them from seeing or hearing the session. Likewise, the provider may ask if you are the only one partaking in your session, and may also reserve the right to request non-patients (other than legal guardians) to leave the room.
- Your session may end before all problems are known or treated. It is up to you to follow up for more care if your health problem does not go away.
- Before your session, you may want to ask how much of the cost will be covered by your insurance and how much you may owe.

**TELEMEDICINE SESSION:**

During your telemedicine session:

- The provider and the staff will introduce themselves.
- The provider may talk to you about your health history, exams, x-rays, or other tests. Other providers may take part in this discussion.
- A visual and/or partial physical exam may take place. This may happen by video and/or audio or with other technology tools. A nurse or other healthcare staff may be in the room with you to help with the exam
- Non-medical staff may be in the room to help with the technology.
- Video and/or photo records may be taken, and audio recordings may be made.
- The provider will take notes, and a report of the session will be placed in your doctor's medical record. You can get a copy from your doctor.

All laws about the privacy of your health information and medical records apply to telemedicine. These laws also apply to the video, photo, and audio files that are made and stored.

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**RISKS AND COMMON PROBLEMS:**

Many patients like telemedicine because they do not have to spend time and money on travel to see a healthcare provider in person. Also, they can see a provider who they might not be able to see otherwise.

Technology can make getting health care easy, but there can also be some problems:

- If there are equipment or Internet problems, then your diagnosis or treatment could be delayed.
- Records or images that are taken and sent may be poor quality. This can delay or cause problems with your diagnosis or treatment.
- The records sent for review before the session may not be complete. If this happens, then it may be hard for the telemedicine provider to use his or her best judgment about your health problem. For instance, you could react to a drug or have an allergic response if the provider does not have all of the information that he or she needs.
- There could be problems with Internet safety ("hackers"). If this happens, then your medical records may not stay private.
- If there is a technology problem, the information from your session may be lost. This would be outside the control of your doctor and telemedicine provider.
- Without a "hands-on " exam, it may be hard to diagnose your problem.
- You may still require an ‘in-person’ office visit if the provider deems a personal visit is needed to help diagnose or treat a medical problem

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## AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my physician named above to release health information identifying me (name, address, phone number, dob; including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

- A detailed description of the information to be released.
- To whom may the information be released [name(s) or class(es) or recipients].
- The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual).
- Expiration date or event relating to the individual or purpose of for the release.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon this authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office to the attention of the Office Manager.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

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**PATIENT ACKNOWLEDGEMENT:**

This form/email gives me the "facts about" and "risks of" telemedicine sessions. By (electronically or manually) signing this form (e-signature), I agree that I have read, understood, and acknowledged the terms provided (via email, attachment or print) with regard to "PATIENT AUTHORIZATION AND CONSENT FORM - FOR TELEMEDICINE SESSIONS" section. I also confirm by my signature below that (i) I have been able to ask questions about telemedicine sessions, (ii) all of my questions have been answered, (iii) I have been told the name and credentials of my telemedicine provider, and (iv) I agree to take part in a telemedicine session.

I have read and understood the policies set forth in this transmission (email, fax, print or attachment) and agree to adhere to your policies. I have also been provided an opportunity to review or have received the notice of privacy practices, patient authorization and consent form for telemedicine sessions, and authorization for release of identifying health information.

I will submit these signed documents in its originally provided form via fax, secure email and/or mail (via postal service).

An e-signature can be accepted if your signature matches an official state/federally issued identification with photo ID (e.g. driver's license or passport) on file.

***Signature of Patient, Parent/Guardian, or Responsible Party***

[E-]Sign your name here: / _____ / (seal) Date : _____

If Minor or have a Legal Guardian, then please also fill out below:

Relationship to Patient (if Responsible Party is not Patient or if Patient is a Minor):
_____

Witness Signature
[E-]Sign your name here: /_____/ (seal) Date: _____

Uniform Electronic Transactions Act of 1999 (UETA) allow for emailed and faxed contracts to be legally binding and the Electronic Records and Signatures in Commerce Act (2000) law grants electronic signatures on contracts the same weight as those executed on paper, except for student loans, wills, leases, deeds, adoption papers, divorce papers, court orders, notices of termination of leases, notice of repossessions, and notices of foreclosure. "E-signature" can be a secure digital signature; it can also be a typed name or a digitized image of a handwritten signature.