Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues

- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective Date of this Notice: December 3, 2018, until further changes are disclosed.
- Privacy official contact: Office Manager or via email: info@qualityphysiciangroup.com

____________________________ _____________

Patient Signature Date

PATIENT REGISTRATION FORM

PATIENT INFORMATION				
Name: LAST FIRST M.I.				**Gender** Male ☐ Female ☐
Date of Birth	**Primary Care Physician (PCP):**			
Address:	**City**:	**State**:	**Zip Code**:	
Home or Cell phone	**Email:**			
Pharmacy name	**Pharmacy address**			
Emergency contact name	**Relationship**			
Home Phone	**Alternate Phone**			

PRIMARY INSURANCE & SUBSCRIBER INFORMATION			
Primary Insurance Name:	**Relationship to Subscriber:**		
Subscriber's Name: LAST FIRST M.I.			
Subscriber ID #	**Group #**	**Plan #**	

SECONDARY INSURANCE			
Secondary Insurance Name:	**Relationship to Subscriber:**		
Subscriber's Name: LAST FIRST M.I.			
Subscriber ID #	**Group #**	**Plan #**	

I authorize Quality Physician Group, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Quality Physician Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that I will be assessed the bank charge for each check returned due to insufficient funds. In the event of default, I (We) promise to pay legal interest on the indebtness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note. I hereby authorize Quality Physician Group to release all information necessary to secure payment and treatment.

____
Patient Signature

____
Date

Authorization for Release of Medical Records

Patient's Name:______________________________Date of Birth: __________________

Patient's Address: ____

____

I hereby authorize Release of Medical Information:

From: ________________________ Fax: ____________

To: **Quality Physician Group** Fax: **855-642-1936**

This Information is subject to limitation as Indicated below (patient must initial all responses):

( ) Covering Medical Records for office visits, labs diagnostic studies, procedures etc.

For the last____________months / years or Since _______________

( ) No limitations placed on dates, history of mental Illness, or diagnostic and therapeutic information, Including any treatment for alcohol or drug abuse, infectious disorders Including HIV/AIDS test results and/or status.

( ) Confined to Medical Records or information regarding the diagnostic and treatment of the following medical conditions: ____

I understand and acknowledge that this authorization extends to all of any part of the records designated above, which may include treatment for physical and mental illness, alcohol/drug abuse and/or HIV/AIDS test results or diagnoses.

Law protects the confidentiality of the above medical records against further disclosure. Except as implicit in the purpose of this disclosure, Federal regulations (42CFR, Part 2) prohibit recipient (s) from making any further disclosure or It without the specific written consent of the person (s) to whom it pertains, or as otherwise permitted be such regulation. A General authorization for the release of medical or other information is NOT sufficient for this purpose.

This authorization is subject to written revocation at any time except to the extent that action has already been undertaken is reliance thereon and is valid for 60 days.

Signature:___________________________________ Date: _____________________

HIPAA Release Form

Name:___________________________________ Date of Birth:_______________

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_______________________________________

[ ] Child(ren)_____________________________________

[ ] Other____

Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell

Number:_______________________

If unable to reach me:

[ ]you may leave a detailed message

[ ] please leave a message asking me to return your call

The best time to reach me is (*day*)____________________between (*time*)___________

Signed:_______________________________________Date:_____ ____ ______

Telehealth Consent Form

1. I hereby authorize Quality Physician Group to use the telehealth practice platform for telecommunication for evaluating, testing, and diagnosing my medical condition.

2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.

3. I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.

4. I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.

5. I agree that my medical records on telehealth can be kept for further evaluation, analysis, and documentation, and in all of these, my information will be kept private.

6. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Patient name:______________________________ Date: ________________________

Signature: ________________________________

Waiver, Release, and Assumption of Risk
for QUALITY PHYSICIAN GROUP, PLLC

Express assumption of risk: I, the undersigned, have voluntarily requested for QUALITY PHYSICIAN GROUP, PLLC (hereinafter "Company") to perform certain medical services (hereinafter "Services"). I also understand that there is currently a worldwide pandemic due to COVID-19.

These pandemic related risks include, but are not limited to injuries, disease, infection, physical changes, disability, or death. I understand that these risks could be due to actions on the part of myself, other people around me, or Company staff; due to improper use or failure of equipment; or due to any other foreseeable or unforeseeable risk to my person during the COVID-19 pandemic. I am also aware that attending any public location, or interacting with any other individual, including but not limited to Company staff, can present health risks due to infectious diseases such as COVID-19, and that any and all preventive measures may not be sufficient in preventing the spread of certain diseases. I also understand and acknowledge that by receiving these Services offered by Company I am placing myself at the potential risk of contracting certain contagious diseases, and I voluntarily and knowingly assume the risk of contracting such infection. I willingly and voluntarily waive and release Company of any liability resulting from my contracting such a disease while receiving these Services. I willingly acknowledge and agree to assume full responsibility for these risks and accept full responsibility for any illness, injury, disability, or death that may result from my voluntary participation.

Release: In consideration of the above-mentioned risks and hazards and in consideration of the fact that I am willingly and voluntarily participating in these Services offered by Company, I, the undersigned, hereby now and forever release Company, their principals, members, managers, agents, employees, and volunteers from any and all liability, claims, demands, actions or rights of action, which are related to, arise out of, or are in any way connected with my participation, including those allegedly attributed to the negligent acts or omissions of the above mentioned parties. This agreement shall be binding upon me, my successors, representatives, heirs, executors, assigns, or transferees. If any portion of this agreement is held invalid or unenforceable, I agree that the agreement will be interpreted to conform with current language to the maximum extent that is permitted, and that the remainder of the agreement shall remain in full legal force and effect.

For myself, and in the case that I am signing on behalf of a minor child, I also give full permission for any person connected with Company to administer these Services as requested. I understand that in the case of serious illness or injury, I am responsible to call for medical and or surgical care for myself or the minor child and to transport myself or the minor child to a medical facility deemed necessary for the well-being of myself or the minor child.

Waiver and Indemnification: I, the undersigned, recognize that there are risks involved in the receipt of these Services in-person during this pandemic. Therefore, I the participant, accept any and all financial responsibility for any illness, injury, disability, or death that I may cause either to myself or to any other individual due to my negligence, gross negligence, or willful or purposeful misconduct. Should the above-mentioned parties, or anyone acting on their behalf, be required to incur attorney's fees and costs to enforce this agreement, I agree to reimburse them for such fees and costs. I further agree to indemnify, release, and hold harmless Company, their principals, members, managers, agents, employees, and volunteers from liability for the illness, injury, disability, or death of any person(s), and damage that may result from my infection of COVID-19. I acknowledge and agree that no warranties or representation have been made to me regarding the results I will receive from these Services. I understand that results are unique to every individual and may not be similar. I am aware of alternative Service options including telehealth.

I, the undersigned, have thoroughly read and understood the foregoing waiver, release, and assumption of risk, and I understand that by signing this agreement, I will be bound by all its requirements and obligations. I represent and warrant that I am signing this agreement freely and willfully and not under fraud or duress. I understand that by signing this form I am waiving valuable legal rights that I, my heirs, or my assigns may have.

Patient name__________________________________**Date:** ______________________

Signature __________________________________

No-show Policy

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Quality Physician Group sends text message and email reminders 5 days in advance of the appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours notice. If you are unable to reach the office, please leave a detailed voice message.

If you do not cancel or reschedule your appointment with at least 24 hours notice, we may assess a **$25** "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

Patient name:_____________________________
Signature:_________________________________
Date:_____________________________________