

We are excited that you and your family have chosen Sol Mental Health. Prior to your first appointment, please complete the following paperwork. This will allow us to maximize the amount of time you and your child will have with the treating clinician.

Please note: if there has been any legal proceedings or actions that have affected the decision-making authority regarding the minor child (such as divorce proceedings, paternity proceedings, etc.), then all paperwork must be signed by both of the child's parents. If only one parent will be signing the paperwork, you **must** also bring legal documentation to your appointment that shows that the signing parent has medical decision-making authority or sole legal custody of the child. Examples of this paperwork could include a divorce decree or custody decree.

If you have any questions, do not hesitate to contact us at [insert phone number here]. We look forward to seeing you soon.

-Sol Mental Health



## Child/Adolescent Patient Questionnaire

*Please complete and return this questionnaire 48 hours prior to your scheduled intake.*

Date:

### **Demographics:**

Completed by:

Child's legal name

Child's preferred name

Child's gender identity

Child's preferred pronoun(s)

Parent or guardian(s) name:

Parent or guardian(s) phone number:

Parents are [choose one]

- Single
- Married
- Divorced
- Remarried
- Widowed
- Cohabiting

If divorced, what are the custody arrangements? \_\_\_\_\_ (please bring copy of custody agreement to first appointment for the chart)

Ethnicity

Religion

### **School History:**

Current grade level:

Current school:

School phone:

Does \_\_\_\_\_ have a current or psat Individualized Education Plan (IEP) or 504 plan? Yes/No

If so, please list:

Any recent disciplinary actions, expulsions, suspensions?

**Describe what brings you (/your child if filled out by parent guardian) in for treatment today:**



**Which of the following are areas of concern (choose all that apply)?**

- Depression
- Anxiety
- Panic attacks
- Inattention
- Hyperactivity/impulsivity
- Nightmares/flashbacks
- Changes in sleep
- Repetitive behaviors
- Alcohol or substance use
- Intrusive thoughts
- Impulsive behaviors
- Difficulty navigating social situations
- Relationship conflicts
- Self-harm or suicidal thoughts
- Thoughts of hurting others
- Traumatic event(s)
- Difficulty with school
- Other \_\_\_\_\_

**Medical History:**

Pediatrician:

Last visit:

Medical conditions/diagnoses:

Current medications (both psychiatric and medical):

Medication	Dose	Frequency	Who prescribes?

Allergies:

TBI/Concussion History:  Yes  No; if yes please describe:

Seizure History:  Yes  No; if yes please describe:

If applicable, pregnancy history/due date (BIRTH PERSON): (pregnancies, miscarriages, any complications):

**Health History:**

Please describe health in the following areas:

Nutrition, diet, and appetite (for example, changes in appetite or dietary restrictions): \_\_\_\_\_

Physical activity (for example, how much exercise do you get each week): \_\_\_\_\_

Sleep (for example, how many hours do you sleep each night): \_\_\_\_\_

**Family Health History**

1. Family Medical History: \_\_\_\_\_
2. Family Psychiatric History: \_\_\_\_\_
3. Family Substance Use History: \_\_\_\_\_

[ ] If family health history unknown, check here



**Childhood/Family History:**

Birth place:

Siblings:

**PSYCHIATRIC HISTORY:**

Have you (/your child if filled out by parent/guardian) ever been diagnosed with a mental health condition (including intellectual delay/disability)? Please describe.

Please list all current and past psychiatric medications prescribed. Include approximate years.

Current psychiatric medications (include dose)	Previous psychiatric medications (include dose)

**Psychiatric Treatment History:** (Include dates, clinician name, outcome)

- Outpatient (office-based):
- Inpatient (emergency room / hospital-based):
- Residential:
- Partial Hospitalization:
- Intensive Outpatient:
- Other:

**Please check substances you (/your child if filled out by parent/guardian) currently use/have used in the past: (describe how recent/often)**

- |                                    |  |   |
|------------------------------------|--|---|
| <input type="checkbox"/> Caffeine: | <input type="checkbox"/> Alcohol:      | <input type="checkbox"/> Benzodiazepines: |
| <input type="checkbox"/> Nicotine: | <input type="checkbox"/> Stimulants:   | <input type="checkbox"/> Opioids:         |
| <input type="checkbox"/> Cannabis: | <input type="checkbox"/> Psychedelics: | <input type="checkbox"/> Other:           |

**Have you (/your child if filled out by parent/guardian) ever experienced hearing sounds others can't hear or seeing things others can't see?**

**History of self-harm or suicide attempts:**

**Do you (/your child if filled out by parent/guardian) have any legal history, such as charges, upcoming hearings, loss of license, current probation, incarceration history, or arrest history? Please describe if yes:**

**Concluding Questions**

What would you (/your child if filled out by parent/guardian) describe as your strengths?

What are your (/your child's if filled out by parent/guardian) goals for treatment? What do you want to be different, have more/less of?

Is there anything else you (/your child if filled out by parent/guardian) would like us to know about you that has not been asked already?

## Practice Policies

### Financial Consent & Insurance Billing

This agreement shows my commitment to pay for the treatment I receive. I agree to pay for the services rendered at each session or in accordance with an established payment plan. Insurance may cover part, or all the cost of treatment, and I understand that Sol Mental Health will attempt to charge the correct copay or allowable amount at time of service. However, I understand that it is **my responsibility to check my coverage and be knowledgeable about my benefits**. I also understand that there may be some types of treatment that may not be covered by insurance but may be clinically recommended.

### Out-of-Network & Out-of-Pocket

#### **Medical Services**

60-minute medication management session:

**\$200**

30-minute medication management session:

**\$150**

#### **Therapy Services**

60-minute intake session: **\$200**

60-minute psychotherapy session: **\$150**

60-minute group psychotherapy session: **\$50**

### Documentation Requests

Documentation requests must be made utilizing the following secure methods:

<https://requestmanager.healthmark-group.com/register>

<https://www.collectivebh.com/request-medical-records/>

Phone: 800-659-4035

Email: [status@healthmark-group.com](mailto:status@healthmark-group.com)

All documentation requests will be handled within 30 calendar days.

Documentation requests, including, but not limited to, medical records, legal letters, accommodation letters, short term disability paperwork, detailed treatment summaries, IEP documentation, ESA letters, may incur a fee based upon length, time spent, and clinicians involved.

### Fee Policy

I understand that I must call to cancel an appointment **at least 48 hours** (2 business days) before the appointment time (weekend days and holiday days do not count towards the minimum 2 business day requirement). If I do not cancel or do not show up for my behavioral health appointment, I will be charged **\$100** for individual appointments and **\$50** for group appointments. I agree to pay for appointments that are not cancelled or those where I fail to give proper notice that I will not attend. Certain exceptions for unforeseen or unavoidable situations can be made at the exclusive discretion of Sol Mental Health. I understand that insurance does not pay for appointments that are not cancelled, so I will be solely responsible for the cost. **Fees will also apply to late arrivals and requests for abbreviated appointments.**

### Patient Rights & Important Information

1. Generally, the information provided by and to me during therapy sessions is legally confidential. Whenever the information is legally confidential, the clinician cannot be forced to disclose the information without your consent.

2. There are exceptions to the general rule of legal confidentiality. Be aware that legal confidentiality will not apply in a criminal or delinquency proceeding. There are other exceptions: the clinician will identify these to me as the situations arise during treatment, but, briefly, these are (1) Imminent threat of bodily harm to self or identifiable other; (2) being assessed as gravely disabled, as a result of a psychiatric disorder; (3) Child/elder abuse or neglect; (4) When you or your representative files a lawsuit or grievance against your clinician (5) A court order requiring Sol Mental Health to turn over records; (6) If you are in treatment by order of a court of law, the results of the treatment ordered must be revealed to the court; (7) If there is suspected threat to national security to federal officials, the clinician is required to report this to law enforcement. The clinician is not required to inform you of actions in this regard, however, if a legal exception arises during treatment, if feasible, you will be informed accordingly; (8) If clinical information discussed in a therapy session is documented in your medical record, then the additional exceptions outlined in the HIPAA Notice of Privacy Practices will apply.
3. Sol Mental Health prohibits harassment of any kind, in person, via email, or via phone, and will take appropriate and immediate action in response to complaints or knowledge of violations of this policy. For purposes of this policy, harassment is any verbal or physical conduct designed to threaten, intimidate or coerce an employee, co-worker, or any person working for or on behalf of Sol Mental Health. Violation of this policy could lead to your dismissal.

#### **Setting Expectations for your First Appointment**

1. Your initial evaluation appointment is for the purpose of diagnosis and evaluation only; it does not necessarily constitute the formation of a treatment relationship. We may require more than one appointment to complete your evaluation. This may happen if more time is required, we need to contact past and/or current providers to gather supporting information, or if we need to order additional testing or laboratory workup.
2. There is no guarantee that you will receive prescriptions at the end of your first appointment if seeing a prescribing clinician. If you require new prescriptions urgently, particularly for a controlled substance, please contact your current care provider or consider seeking care in an urgent care or emergency room setting as withdrawal from some controlled substances can be life-threatening.
3. There are times when we will only be able to work with you when you give us permission to receive healthcare information from current and past providers. Speaking with other providers allows us to provide the best care possible by ensuring that important clinical information is included in your evaluation.
4. In some cases, we may recommend you pursue care at a facility which can offer specialized services which we cannot. This is to ensure we are doing our part to direct you to the best and most appropriate care.

#### **Telehealth Contract**

1. Confidentiality cannot be guaranteed by the clinician in a virtual platform. You understand that you need to be in a quiet, private setting wherein they will not be overheard and can speak freely.

2. You understand that telehealth services bring with them the risk of technological difficulties and Sol Mental Health will do everything possible to address any issues on our end during a session. Sessions will not be extended due to technological difficulties. You understand that you have the responsibility to ensure a good connection is available for your appointment times.
3. Your clinician must know your location during every telehealth session. You agree to provide your address or location for these sessions. You agree to inform the clinician if this changes at any point throughout your care. I understand that Sol Mental Health cannot provide virtual care to patients that are located out of state for any reason (including, for example, temporary leisure/work travel or for school).
4. You agree to take telehealth sessions seriously and present as you would in an in-person session. This includes, but is not limited to, being on time, having devices turned off, being appropriately dressed, and focusing fully on the session. You agree that you will not use substances during a telehealth therapy session.
5. Telehealth sessions may be discontinued at any time by the clinician or by the patient if these standards are not met.
6. For patients seeing a prescribing clinician, unless advised otherwise by your treating clinician, the prescription of a controlled substance will require at least one in-person (e.g., face-to-face) appointment with your clinician at Sol Mental Health. Additionally, prescriptions for controlled substances cannot be sent to pharmacies located out of state.

**In Case of Emergency**

Sol Mental Health does not provide emergency services and is not available 24/7. If I find myself or my child in a life-threatening situation, I agree to take the necessary steps to keep myself and my child safe, up to and including calling 911, going to an emergency room, or contacting local crisis services:

**Frederick County Mobile Crisis Service: 301-662-2255**

**Or**

**Montgomery County Crisis Center: 240-777-4000**

*I have read and understand the above statements, I understand my rights as a patient, and consent to evaluation/treatment. If treatment is for a minor, I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of the service provider about the above information at any time.*

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian's Signature, 1 (if applicable)

\_\_\_\_\_  
Guardian's Printed Name, 1

\_\_\_\_\_  
Date



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Guardian's Signature, 2 (if applicable)

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Guardian's Printed Name, 2

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Date

### Crisis Notice

Sol Mental Health is an outpatient mental health practice, and not available after-hours, on weekends, or during holidays. If you find yourself or your child in a life-threatening situation while waiting for your first appointment with us or while in treatment with us, you agree to take the necessary steps to keep yourself and your child safe. These may include **calling 911** or **proceeding directly to your closest emergency room**. Here are some additional resources within the community that may provide emergency services and support:

- **Crisis Intervention Hotline of Houston**  
Call: 832-416-1177
- **Harris Country Suicide Hotline**  
Call: 1-800-784-2433 (1-800-SUICIDE)
- **National Suicide Prevention Lifeline**  
Call: 1-800-273-TALK (1-800-273-8255)  
Call: 9-8-8  
Text: 741741

Or, consider proceeding to a Houston-area crisis clinic:

Memorial Hermann Mental Health Crisis Clinic (Spring Branch)  
10780 Westview Dr., Suite C  
Houston, TX 77043  
713-338-6422

Memorial Hermann Mental Health Crisis Clinic (Meyerland)  
4850 W. Bellfort St.  
Houston, TX 77035  
713-338-6422

Memorial Hermann Mental Health Crisis Clinic (Northeast)  
18838 S. Memorial Dr., Suite 106  
Humble, TX 77338  
713-338-6422



**Authorization and Consent to Treatment**

**Assignment of Benefits and Authorization to Release Medical Information.** I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

**Guarantee of Payment & Pre-Certification.** In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

**Consent to Treatment.** I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being; however I may refuse any particular treatment or procedure.

If I request or initiate a telehealth visit (a "virtual visit"), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

**Consent to Call, Email & Text.** I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at [privacy@priviahealth.com](mailto:privacy@priviahealth.com).

**HIPAA.** I understand that my provider's Privacy Notice is available on my provider's website and at [priviahealth.com/hipaa-privacy-notice/](http://priviahealth.com/hipaa-privacy-notice/) and that I may request a paper copy at my provider's reception desk.

**I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,\* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.**

Printed Name of Patient: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

Name and Relationship of Person Signing, if not Patient: \_\_\_\_\_

\*Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.



## **FINANCIAL POLICY**

We are pleased that you have chosen us as your healthcare provider. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care. We require all patients to sign our *Authorization and Consent To Treatment Form* before receiving medical services. That form confirms that you understand that the healthcare services provided are necessary and appropriate and explains your financial responsibility with respect to services received as set forth in this policy.

## **PATIENT RESPONSIBILITY**

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. When the insurance plan provides immediate information regarding patient responsibility, we may request payment for your share when you schedule and/or when you present for your appointment. As a convenience to you, we can save a credit card on file to settle your account when you check in or out. You may receive an estimate for your patient responsibility prior to or at the time of your service. If there is a difference in the estimated patient responsibility, we will send you a statement for any balance due. If a credit balance results after insurance pays, we will apply the credit to any open balance on your account. If there are no open balances, we will issue a refund.

If you have an Annual Wellness Visit or Physical/Preventative Exam, but need or request additional services, we may bill you for those additional services. All services for patients who are minors will be billed to the custodial parent or legal guardian. If you are uninsured and demonstrate financial need and complete the required paperwork, financial assistance may be available. If you have a large balance, a payment plan may be available.

## **INSURANCE**

We ask all patients to provide their insurance card (if applicable) and proof of identification (such as a photo ID or driver's license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e., self-pay). We accept assignment of benefits for many third party carriers, so in most cases, we will submit charges for services rendered to your insurance carrier. You are expected to pay the entire amount determined by your insurance to be the patient responsibility. Keep in mind that our fees are for physician services only; you may receive additional bills from laboratory, radiology or other diagnostic related providers.

### **You are responsible for understanding the limitations of your insurance policy, including:**

- If a referral or authorization is necessary for office visits. (If it is required and you do not have the appropriate referral or authorization, you may be billed as an uninsured patient).
- What prescribed testing (lab, radiology, etc.) is covered under your insurance policy. (If you choose to have non-covered testing, we will require full payment at the time of your visit.)
- Any co-payment, coinsurance or deductible that may apply

## **NO SURPRISES ACT / GOOD FAITH ESTIMATE OF CHARGES**

If you do not have insurance or are not using insurance to pay for your care, you have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the NO SURPRISES ACT, health care providers must give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least one (1) business day before your medical service or item.
- You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call 1-888-774-8428.

## **CARD-ON-FILE PROCESS**

You may be requested to provide a credit card when you check-in for your visit. The information will be held securely until your insurance has paid their share and notified us of any additional amount owed by you. At that time, we will notify you that your outstanding balance will be charged to your credit card five (5) days from the date of the notice. You may call our office if you have a question about your balance. We will send you a receipt for the charge.

This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork

and ultimately helps lower the cost of healthcare. Your statements will be available via your patient portal and our Customer Support line is available to answer any questions about the balance due. If you have any questions about the card-on-file payment method, please let us know.

## **YOUR RESPONSIBILITIES**

**Outstanding Balances.** After your visit, we will send you a statement for any outstanding balances. We send out statements when the balance becomes the patient's responsibility.

All outstanding balances are due on receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. Your outstanding balances can be paid conveniently via our patient portal.

We may add a finance charge of 1.33% of your outstanding account balance every month if you do not pay your account in full.

**If you have an outstanding balance for more than ninety (90) days, you may be referred to an outside collection agency and charged a collection fee of 23% of the balance owed, or whatever amount is permitted by applicable state law, in addition to the balance owed.** In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and/or you may not be allowed to schedule any additional services unless special arrangements have been made.

**Interpreter and Translation Services.** If you have requested interpreter or translation services for your visit and you miss your appointment without cancelling at least forty-eight (48) hours prior to your scheduled appointment, you may be charged the amount that the translation or interpreter service charges your care center for such missed appointment.

*Additional information about our financial policies is available on our website at [priviahealth.com](http://priviahealth.com).*

***Thank you for choosing us as your healthcare provider!***



## Notice of Privacy Practices

This Notice is provided to you pursuant to the privacy regulations enacted as a result of the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**. This joint notice of privacy practices describes how your medical information may be used and disclosed and how you can get access to your information. This Notice applies to all your medical information created or maintained by the members of the Privia Health Affiliated Covered Entity / Organized Healthcare Arrangement (collectively referred to in this Notice as "Privia" and is further defined in Section B below). **Please review this notice carefully.**

### A. OUR COMMITMENT TO YOUR PRIVACY

Privia is committed to maintaining the privacy of your health information. We are required by law to (i) maintain the privacy of your health information; (ii) provide you with this notice of our legal duties and privacy practices with respect to your health information; (iii) follow the terms of the notice of privacy practices currently in effect; and (iv) notify you if there is a breach of your health information. We must also provide you with the following important information: (a) how we may use and disclose your health information; (b) your privacy rights; and (c) our obligations concerning the use and disclosure of your health information.

This Notice of Privacy Practices is NOT an authorization; rather it describes how we, our Business Associates, and their subcontractors may use and disclose your Protected Health Information to carry out treatment, payment, or health care operations, and for other purposes as permitted or required by law. It also describes your rights to access and control your Protected Health Information

*"Protected Health Information" ("PHI")* means information that identifies you individually; including demographic information, and information that relates to your past, present, or future physical or mental health condition and/or related health care services.

The terms of this notice apply to all your PHI created or maintained by Privia. We reserve the right to revise or amend this Notice at any time. Any revision or amendment to this notice will be effective for all of your records that we created or maintained in the past and for any of your records that we may create or maintain in the future. We will post a copy of our current Notice online at [priviahealth.com/HIPAA](http://priviahealth.com/HIPAA) and on all Privia care center websites. You may request a copy of our most current Notice at any time.

### B. PERSONS/ENTITIES COVERED BY THIS NOTICE

Your provider is part of an Affiliated Covered Entity and/or Organized Health Care Arrangement (OHCA) by virtue of his or her affiliation with a member of the Privia Medical Group or Texas Health Care family, Health First Medical Group, Health First Privia Medical Group, Premier Medical Group, Privia Medical Group Tennessee and/or a Privia Quality Network (Privia Health's Clinically Integrated Networks and Accountable Care Organizations) (collectively these entities are referred to as "Privia"). For the purposes of complying with federal privacy and security requirements, the above-described entities have designated themselves as an ACE and/or OHCA. An OHCA is a clinically integrated care setting in which patients may receive care from multiple providers who share a common set of privacy practices. Privia providers have agreed to follow the terms of this Notice when providing services through Privia. Legally separate covered entities that are affiliated may designate themselves as a single covered entity or ACE for purposes of the HIPAA privacy rule. Although each care center is legally separate and responsible for its own acts, Privia coordinates privacy practices among the Privia care centers. Patient information is shared across the Privia ACE/OHCA for treatment, payment, and healthcare operations related to the ACE/OHCA. Your PHI can be shared across the ACE/OHCA for the purposes of your treatment, payment, and healthcare operations. When PHI is shared for healthcare operations, the person or organization using your PHI must have a relationship with you, unless your PHI is used for quality assurance, utilization review, and peer review purposes.

**NOTE:** his notice applies to all care centers affiliated with Privia, including those whose providers are members of Privia Medical Group Mid-Atlantic, Privia Medical Group – Georgia, Privia Medical Group – Gulf Coast, Texas Health Care / Privia Medical Group – North Texas, Health First Medical Group, Health First Privia Medical Group, Premier Medical Group, and Privia Medical Group Tennessee. The complete list of Privia providers for whom this Notice of Privacy Practices applies can be viewed at [priviahealth.com/HIPAA](http://priviahealth.com/HIPAA).

**IMPORTANT:** Privia may disclose your PHI to providers affiliated with the Privia ACE/OHCA and other independent medical professionals in order to provide patient treatment and for payment purposes and healthcare operations. Although providers affiliated with the Privia ACE/OHCA have agreed to follow this Notice and participate in the Privia privacy program, they are independent professionals and Privia expressly disclaims any responsibility or liability for their acts or omissions relating to your care or privacy/security rights.

### C. CONTACT FOR QUESTIONS

For more information or questions about the privacy policies of the Privia ACE/OHCA, please contact:

Privacy Officer  
950 N Glebe Rd, Suite 700  
Arlington, VA 22203  
(571) 317-0679  
[privacy@priviahealth.com](mailto:privacy@priviahealth.com)

### D. USE AND DISCLOSURE OF YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (PHI)

**1. Treatment.** Privia may use or share your PHI to provide medical treatment or services for you and manage and coordinate your medical

care. Privia may disclose your PHI to physicians and health care providers (including pharmacists), durable medical equipment (DME) vendors, surgery centers, hospitals, rehabilitation therapists, home health providers, laboratories, nurse case managers, worker's compensation adjusters, etc. to ensure that your medical providers have the necessary information to diagnose and provide treatment to you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may affect the healing process. Privia may also disclose your PHI to individuals who are directly involved in your care, including family members, friends or other care providers. If you participate in a virtual visit (telehealth), your information will be shared electronically via a secure transmission to facilitate the virtual visit.

**2. Payment.** Privia may use and disclose your PHI in order to bill for services provided and collect payment from health plans or other entities. For example, we may disclose PHI to your health insurance plan so it will pay for your services, determine your eligibility for coverage, or to obtain prior approval from the insurer to cover payment for treatment. Privia also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, including family members. Privia may also disclose your information to a collection agency to obtain overdue payment or to a regulatory agency or insurance company to determine whether the services we provided were medically necessary or appropriately billed.

**3. Health Care Operations.** Privia and its providers may use and disclose your PHI to run our businesses, improve your care, and contact you when necessary. For example: We may use or disclose your PHI: (1) to conduct quality or patient safety activities, population-based activities relating to improving health or reducing health care costs, case management and care coordination, and contacting your health care providers and you with information about treatment alternatives; (2) when conducting training programs or performing accreditation, licensing, or credentialing activities; (3) when conducting or arranging for medical review, legal services, and auditing functions; and (4) for our proper management and administration, including customer service, resolving complaints, strategic planning, etc. In addition, we may use or disclose de-identified information or a limited data set for certain healthcare operations purposes. We may also record your visit in order to facilitate the documentation of your care by your provider via a scribe or virtual scribe service.

**4. Appointment Reminders, Check-In and Results.** Privia may use and disclose your PHI to contact you and remind you of an appointment. Privia may use a sign-in sheet at the registration desk and call you by name in the waiting room when your provider is ready to see you. Privia may also use your PHI to contact you about test results. Privia may leave a message reminding you of an appointment or the results of certain tests, but will leave the minimum amount of information necessary to communicate this information.

**5. Treatment Options and Health-Related Benefits and Services.** Privia may use and disclose your PHI to inform you of treatment options or alternatives as well as certain health-related benefits or services that may be of interest to you. Privia may also use and disclose your PHI to describe health-related products or services (or payment for such products or services) provided through your benefit plan or to offer information on other providers participating in a healthcare network that we participate in.

**6. Disclosures to Family or Friends.** Privia may disclose your PHI to individuals involved in your care or treatment or responsible for payment of your care or treatment. If you are incapacitated, we may disclose your PHI to the person named in your Durable Power of Attorney for Health Care or your personal representative (the individual authorized by law to make health-related decisions for you). In the event of a disaster, your PHI may be disclosed to disaster relief organizations to coordinate your care and/or to notify family members or friends of your location and condition.

**7. Disclosures Required By Law.** Privia will use and disclose your PHI when we are required to do so by federal, state or local law. For example, Privia may disclose PHI to comply with child and elder abuse reporting laws or to report certain diseases, injuries or deaths to state or federal agencies.

## **E. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES**

**1. Public Health Reporting.** Privia may disclose and may be required by law to disclose your PHI for certain public health purposes. For example, Privia may disclose your PHI to the Food and Drug Administration (FDA) regarding the quality and safety of an FDA-regulated product or activity; to prevent or control disease; report births and deaths; to report child abuse and/or neglect; to report reactions to medications or problems with health products; to provide notification of recalls of products; or report a person who may have been exposed to a disease or may be at risk of contracting and/or spreading a disease or condition. In addition, Privia may provide proof of immunizations to a school that requires a patient's immunization record prior to enrollment or admittance of a student if you have informally agreed to the disclosure for yourself or on behalf of your legal dependent.

**2. Health Oversight Activities.** Privia may disclose your PHI to a health oversight agency for investigations, inspections, audits, surveys, licensure and disciplinary actions, and in certain civil, administrative, and criminal procedures or actions, or other health oversight activities as authorized by law.

**3. Lawsuits and Disputes.** Privia may disclose your PHI in response to a court or administrative order, subpoena, request for discovery, or other legal processes. However, absent a court order, Privia will generally disclose your PHI if you have authorized the disclosure or efforts have been made to inform you of the request or obtain an order protecting the information requested. Your information may also be disclosed if required for our legal defense in the event of a lawsuit.

**4. Law Enforcement.** Privia may disclose your PHI if requested by a law enforcement official: (a) regarding a crime victim in certain situations, if we are unable to obtain the person's agreement; (b) about a death we believe resulted from criminal conduct; (c) regarding criminal conduct on our premises; (d) in response to a warrant, summons, court order, subpoena or similar legal process; (e) to identify/locate a suspect, material witness, fugitive or missing person; or (f) in an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

**5. Deceased Patients.** Privia may disclose your PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. In addition, we may disclose PHI necessary for funeral directors to fulfill their responsibilities.

**6. Organ and Tissue Donation.** Privia may disclose your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation or blood banks, as necessary to facilitate donation and transplantation if you are a donor.

**7. Research.** Privia may use and disclose your PHI to researchers for the purpose of conducting research with your written authorization or when the research has been approved by an Institutional Review Board and is in compliance with law governing research. In certain situations, the need for your individual consent may be waived by a Privacy Board.

**8. Serious Threats to Health or Safety.** Privia may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

**9. Military, National Security, and other Specialized Government Functions:** If you are in the military or involved in national security or intelligence, Privia may disclose your PHI to authorized officials. Privia also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct certain investigations.

**10. Workers' Compensation.** Privia will disclose only the PHI necessary for worker's compensation in compliance with worker's compensation laws. This information may be reported to your employer and/or your employer's representative in the case of an occupational injury or illness.

**11. Inmates.** If you are an inmate or in the custody of a law enforcement official, Privia may disclose your PHI to correctional institutions or law enforcement officials as necessary: (a) for the institution to provide health care services to you; (b) for the safety and security of the law enforcement officer or the correctional institution; and/or (c) to protect your health and safety or the health and safety of other individuals.

**12. Minors.** If you are a minor (generally an individual under 18 years old), we may disclose your PHI to your parent or guardian unless otherwise prohibited by law.

## **F. YOUR PRIVACY RIGHTS REGARDING YOUR PHI**

**1. Inspection and Copies.** You may request a copy of, or request to inspect, the PHI that is used to make decisions about you, including medical and billing records and laboratory and imaging reports. You have the right to obtain an electronic copy if it is readily producible by us in the form and format requested, or you may request that we provide a paper copy of your record. You may also request a summary of your record. We will provide your health information, to you or whomever you designate to receive it, usually within thirty (30) days of your request, or fifteen (15) days if your provider is in Texas. Privia may charge a reasonable cost-based fee to cover the costs of copying, mailing, labor and supplies associated with your request. Privia may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. There may be times that your provider, in his or her professional judgment, may not think it is in your best interest to have access to your medical record. Depending on the reason for the decision to deny a request, we may ask another licensed provider chosen by us to conduct a review of your request and its denial.

**2. Confidential Communications.** You may request in writing that we communicate with you in a specific way or send mail to a different address. For example, you may request that we contact you at home, rather than work or by mail. Privia will accommodate all reasonable requests. You do not need to give a reason for your request. We will comply with your request if we are reasonably able to do so.

**3. Amendment.** You may request a correction or amendment of your PHI if you believe it is incorrect or incomplete. You may make a written request for a correction or amendment for as long as your PHI is maintained by or for Privia. Requests must provide a reason or explanation that supports the request. Privia will deny your request if it is not in writing or if, in the provider's opinion, the information is: (a) accurate and complete; (b) not part of the PHI maintained by or for Privia; (c) not part of the PHI that you have the right to inspect and copy; or (d) not created by Privia, unless the individual or entity that created the information is not available to amend the information. Privia will notify you in writing within sixty (60) days if we cannot fulfill your request.

**4. Accounting of Disclosures.** You may request an accounting of certain disclosures that Privia has made of your PHI. This accounting will list the disclosures that we have made of your PHI but will not include disclosures made for the purposes of treatment, payment, health care operations, disclosures required by law, and certain other disclosures (such as any you asked us to make). Your request must be in writing and state the time period for which you want the accounting (not to exceed six (6) years prior to the date you make the request). Privia will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within twelve (12) months. Privia will notify you of the costs involved with any additional request and you may withdraw your request before you incur any costs.

**5. Requests for Restrictions.** You have the right to request that Privia not use or share your PHI for treatment, payment, or health care operations. We are not required to agree to your request, and we may say "no" if we believe it might affect your care. If you pay for a service or health care item out-of-pocket in full, you may ask us not to share that information for the purpose of payment or our operations with your health insurer. In that case, we will approve your request unless a law specifically requires us to share that information.

**6. Health Information Exchange Opt-Out:** You have the right to opt-out of disclosure of your medical records to or via an electronic health information exchange ("HIE") (For example, Surescripts, Commonwell, CareQuality aka The Sequoia Project, ConnectVirginia and/or the Chesapeake Regional Information System for our Patients, Inc. ("CRISP")). However, information that is sent to or via an HIE prior to processing your opt-out may continue to be maintained by and be accessible through the HIE. You must opt out of disclosures to or via an HIE through each of your individual treating providers who may participate in any given HIE. See H. USING TECHNOLOGY TO IMPROVE HEALTHCARE below for more information regarding HIE.

**7. Right to Receive a Notice of a Breach of Unsecured Medical Information.** You have the right to receive prompt notice in writing of a breach of your PHI that may have compromised the privacy or security of your information.

**8. Right to a Paper Copy of This Notice.** You have the right to receive a paper copy of this notice at any time even if you have agreed to receive the notice electronically. You may also obtain a copy of this notice at our website -- [priviahealth.com/HIPAA](http://priviahealth.com/HIPAA) .

**9. Right to File a Complaint.** If you believe your rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services ("HHS"), Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/). All complaints must be submitted in writing. You will not be penalized for filing a complaint.

## **G. ADDITIONAL INFORMATION**

**1. Patient Portal and Other Patient Electronic Correspondence.** Privia may use and disclose your PHI through various secure patient portals that allow you to view, download and transmit certain medical and billing information and communicate with certain health care providers in a secure manner through the portal. For more information on the Privia patient portal, please visit our website at [www.priviahealth.com/signin.html](http://www.priviahealth.com/signin.html).

**2. Your Contact Information: Home and Email Addresses/Phone Numbers.** If you provide us with a home or email address, home/work/cell telephone number, or other contact information during any registration or administrative process we will assume that the information you provided us is accurate and that you consent to our use of this information to communicate with you about your treatment, payment for service and health care operations. You are responsible to notify us of any change of this information. Privia reserves the right to utilize third parties to update this information for our records as needed.

**3. Email or Downloading PHI.** If you email us medical or billing information from a private email address (such as a Yahoo, Gmail, etc. account), your information may not be secure in transmission. We therefore recommend you use your Privia patient portal to communicate with us regarding your care and/or billing issues. If you request that Privia email your PHI to a private email address, we will send it in an encrypted manner unless you request otherwise. Privia is not responsible for the privacy or security of your PHI if you request that we send it to you in an unsecured manner or download or post it on a dropbox, unencrypted USB drive, CD or other unsecure medium. In addition, Privia is not responsible if your PHI is redisclosed, damaged, altered or otherwise misused by an authorized recipient. In addition, if you share an email account with another person (for example, your spouse/partner/roommate) or you choose to store, print, email, or post your PHI, it may not be private or secure.

**4. Sensitive Health Information.** Federal and state laws provide special protection for certain types of health information, including psychotherapy notes, information about substance use disorders and treatment, mental health and AIDS/HIV or other communicable diseases, and may limit whether and how we may disclose information about you to others.

**5. Substance Use Disorder Records and Information.** The confidentiality of patient records maintained by federally assisted substance use disorder rehabilitation programs is protected by Federal law and regulations. Generally, such programs may not disclose any information that would identify an individual as having or being treated for a substance use disorder unless:

- a. the individual consents in writing;
- b. the disclosure is allowed by a court order;
- c. the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; or
- d. as otherwise permitted by law.

(Notwithstanding the preceding, we may disclose certain information that could identify you as having a substance use disorder pursuant to paragraph 6, below.) Violation of these laws and regulations is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not prevent any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

**6. Consent to Disclose Sensitive Health and Substance Use Disorder Information.** The Privia Authorization & Consent to Treat form you sign as part of the registration process includes your consent to the release of federally assisted substance use disorder information, information regarding treatment of communicable diseases and mental health information for the purposes specified in this notice. If you do not wish for this information to be disclosed, you must notify us in writing and we will determine if it is feasible for us to accept your request.

**7. Incidental Disclosures.** Despite our efforts to protect your privacy, your PHI may be overheard or seen by people not involved in your care. For example, other individuals at your provider's office could overhear a conversation about you or see you getting treatment. Such incidental disclosures are not a violation of HIPAA.

**8. Business Associates.** Your PHI may be disclosed to individuals or entities who provide services to or on behalf of Privia. Pursuant to HIPAA, Privia requires these companies sign business associate or confidentiality agreements before we disclose your PHI to them. However, Privia generally does not control the business, privacy, or security operations of our business associates.

**9. Authorization for Other Uses and Disclosures.** Privia will obtain your written authorization for uses and disclosures that are not identified by this notice or otherwise required or permitted by applicable law. Any authorization you provide regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. However, your revocation will not affect actions we have already taken; in other words, we are unable to take back any disclosures of PHI we have already made.

**H. USING TECHNOLOGY TO IMPROVE HEALTHCARE** Health Information Exchange (HIE) enables your healthcare providers to quickly and securely share your health information electronically among a network of healthcare providers, including physicians, hospitals, laboratories and pharmacies. Your health information is transmitted securely and only authorized healthcare providers with a valid reason may access your information.

## **How does HIE Help You?**

Improved access to information will enable us to provide better care for our patients.

- **Improved Care** - Access to information about your health history and medical care gives your healthcare provider a more complete picture of your overall health. This can help your provider make better decisions about your care. The information may also prevent you from having repeat tests, saving you time, money and worry.
- **Emergency Treatment** - In an emergency, your providers may immediately check to see if you have allergies, health problems, test results, medications or previous concerns that may help them provide you with emergency care.
- **Helps to Protect Privacy and Information Security** - By sharing information electronically through a secure system, the risk that your paper or faxed records will be misused or misplaced is reduced.

## **How does HIE help protect your medical information and keep it secure?**

Privia is committed to protecting the privacy and security of your health information, including the sharing and accessing of your information through HIE.

- Every HIE and its participants must protect your private medical information under HIPAA law, as well as applicable state laws and regulations.
- Information shared via HIE is encrypted, meaning it can be accessed only by authorized users. This prevents hackers from accessing your information.
- Every individual who can access your information must have their own user name and password and must receive training before they can access your information.
- The HIE records every time someone accesses your information. Upon request, the HIE can track who accessed your information and provide a report to the Privia Privacy Officer.

## **What HIEs does Privia participate in?**

Privia participates in a number of HIEs, including, but not limited to, Surescripts (provider of medication history), Commonwell, CareQuality aka The Sequoia Project, ConnectVirginia and CRISP. (Note: This list is subject to change.)

*You have choices about participating in HIE.*

Privia recognizes you have certain rights related to how we share your information. You have the following choices:

### **Choice 1: Say Yes. No further action needed.**

If you agree to have your medical information shared through HIE and you have a current Authorization and Consent to Treat form on file, you do not need to do anything. By signing the form, you have granted us permission to share your health information to HIE.

### **Choice 2: Say No Thanks. Follow the Instructions on the HIE Opt-Out Form.**

We recognize your right to choose not to participate in HIE, also referred to as opting-out. If you decide to opt-out of HIE, healthcare providers will not be able to access your health information through HIE. You should understand that providers may still request and receive your medical information from other providers using other methods permitted by law, such as fax, mail or other electronic communication.

If you want to opt-out of participating in HIE, please follow the appropriate procedure as outlined on the Privia HIE Opt-Out Request Form and/or contact the HIE directly. You may download and print the form on your computer or ask for a copy at any Privia care center location. Please read the Opt-Out Request Form carefully and follow the instructions on the form to opt out of HIE.

Please note, your opt-out does not affect health information that was disclosed through HIE prior to the time that you opted out.

### **Choice 3: You can change your mind at any time.**

You can consent today to the sharing of your information via HIE and change your mind later by following the instructions on the opt-out form described under Choice 2.

You can opt out of HIE today and change your mind later by submitting a *Privia HIE Reinstatement of Participation Form* or, in certain cases, by contacting the HIE directly. The reinstatement form is available to download and print on your computer or you may ask for a copy of the form at any Privia care center location. Please follow the instructions on the form to opt back in to HIE.

If you have any questions about HIE, you can email [privacy@priviahealth.com](mailto:privacy@priviahealth.com). To opt-out of HIE, please email [medicalrecords@priviahealth.com](mailto:medicalrecords@priviahealth.com).

**J. CHANGES TO THIS NOTICE.** Privia reserves the right to change this Notice at any time. Privia reserves the right to make the revised or changed Notice effective for medical information we already have about you, as well as for any information we receive in the future. Privia will post the current Notice at registration sites throughout Privia and on our website at [priviahealth.com/HIPAA](http://priviahealth.com/HIPAA).

**K. NO WAIVER.** Under no circumstances will Privia require an individual to waive his or her rights under the HIPAA Privacy Rule or the HIPAA Breach Notification Rule as a condition for receiving treatment.

**L. CONTACT/COMPLAINT INFORMATION.** If you have any questions about this Notice or wish to file a privacy complaint, please contact:

Privacy Officer

950 N Glebe Rd, Suite 700  
Arlington, VA 22203  
(855) 541-9048 (toll free)  
or email [privacy@priviahealth.com](mailto:privacy@priviahealth.com) We may not retaliate against you for filing a complaint.

If your concern relates to a **Texas Health Care / Privia Medical Group – North Texas** provider please contact:

Privacy Officer  
Texas Health Care / PMG – North Texas  
2821 Lackland Road, Ste 300  
Fort Worth, Texas 76116  
(817) 740-8400  
or email [jcopling@priviahealth.com](mailto:jcopling@priviahealth.com)

If your concern relates to a **Health First Medical Group** provider, please contact:

Privacy Department  
6450 US Highway 1  
Rockledge, FL 32955  
(321) 434-7543  
or email [privacy@hf.org](mailto:privacy@hf.org)

If your concern relates to a **Premier Medical Group (TN)** provider, please contact:

Privacy Officer  
P.O. Box 3799  
Clarksville, TN 37043  
(931)245-7000  
or email [privacyofficer@premiermed.com](mailto:privacyofficer@premiermed.com)  
You may also use Privia's on-line Compliance portal to file a complaint on-line:  
[www.priviahealth.complytrack.com/portal](http://www.priviahealth.complytrack.com/portal)

You can file a complaint directly 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 on-line at: [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)

If your provider is licensed in Texas, you can also file a complaint with the **Texas Department of State Health Services Investigations**:  
P.O. Box 141369  
Austin, Texas 78714-1369.  
More information is at: [dshs.texas.gov/hipaa/privacycomplaints.shtm](http://dshs.texas.gov/hipaa/privacycomplaints.shtm)

*Privia Notice of Privacy Practices Effective January 2022*



**Preferred Communication:**

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell 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:** \_\_\_\_\_  **Cell Phone:** \_\_\_\_\_

OK to leave message with detailed information

OK to leave message with detailed information

Leave message with call-back number only

Leave message with call-back number only

**Work Telephone:** \_\_\_\_\_  **Written Communication:** \_\_\_\_\_

OK to leave message with detailed information

Please send all of my mail to my home address on file

Leave message with call-back number only

Please send all mail to THIS address:

\_\_\_\_\_  
\_\_\_\_\_

**Other:** \_\_\_\_\_

**My Preferred Contacts:**

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication, such as to share your test results. **You** have the ability to control access to your patient portal.

Please indicate the person(s) with whom you prefer we share your information below. **Please update this information in writing promptly if your preferences change.**

**Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.**

Note that we generally do not share your information via email; if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact our Patient Experience team at 1-888-774-8428 - Monday – Friday 8 am – 6 pm ET.

•Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Email: \_\_\_\_\_

•Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Email: \_\_\_\_\_

•Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Email: \_\_\_\_\_

**ACKNOWLEDGMENT:** I understand that HIPAA may permit my provider to share my information with other persons **not** named on this form as needed for my care or treatment or to obtain payment for services provided.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(To be signed by patient’s parent or legal guardian if patient is a minor or otherwise not competent)