Welcome to MY DR NOW!

Your "Medical Home"

MY DR NOW is your "Medical Home", where you can be seen for all of your medical needs. Feel free to just walk in or make an appointment in advance. We are here whenever you need us. Providing you with superior healthcare is our number one priority. **This packet is a one-time form which will allow us to know you better. Please carefully fill in the forms as completely and accurately as possible, all blank or unanswered questions/spaces imply a negative response. We ask you to please bring your insurance card and ID to each visit.** Thank you for choosing MY DR NOW. We look forward to serving you!

Overview: MY DR NOW is your medical home. We strive to provide you with all of your Family Practice, Internal Medicine, Pediatric, Orthopaedic Surgery, Sports Medicine, and Urgent Care needs. However, with certain HMO and Medicaid (AHCCCS) plans, we can only provide services if MY DR NOW is designated as your medical home. In other words, if you have an HMO or Medicaid (AHCCCS) plan, MY DR NOW needs to be designated as your primary care physician's office, in order for you to take advantage of all the services we provide.

Refills & Prescriptions: Medication errors involving prescription drugs account for 1.5 million injuries and deaths per year according to the esteemed Institute of Medicine. Of this number, 400,000 cases of medication errors are ***preventable***. In order to minimize preventable medication errors and provide the highest quality care, medication refills are best addressed at the time of your visit with your provider; please bring all of your medications with you at the time of every office visit.
Once an ailment or disease process is stable or controlled, you may receive a 3-6 month supply of medication. *Prior to running out, we ask that you return to the clinic for re-evaluation and to obtain refills, as they will not be refilled over the phone or via facsimile. As customary with industry standards, multiple refills will not be granted for patients seen on an emergent basis, in the urgent care, or as walk-ins.* Refills on antibiotics and narcotics are strictly prohibited. Please note that lost prescriptions will not be refilled and will require a new office visit (this includes self pay patients.) Please also note that the providers at MY DR NOW are unable to see, evaluate, examine, or diagnose patients who are not officially being seen in the clinic.

Office Visits: Based on a report from the National Academy of Sciences' Institute of Medicine, preventable medical errors cause over 98,000 fatalities each year. As we strive to provide the highest quality care to our patients, MY DR NOW has implemented policies to help ensure optimal care. Therefore, the providers at MY DR NOW cannot treat, evaluate, or change the treatment modalities of anyone who is not officially being seen as a patient in the clinic. This policy extends to giving medical advice or changing treatment modalities over the phone. We are always happy to serve our patients, so if there are ever any questions or concerns in regards to your healthcare, please don't hesitate to come in for an office visit and be seen for further evaluation. Clinic policy states that all patients who visit MY DR NOW for any type of care or assistance are required to have a full set of vitals completed at the time of visit.

Cancellation Policy: **As a courtesy to other patients, we ask that you provide us with at least 24 hours notice if you need to cancel or reschedule your appointment. MY DR NOW reserves the right to charge a $25 fee to all patients who are in violation of this policy.**

Co-Pays: **All co-pays are due at the time of service, this includes follow-ups, nurse visits and blood draws. All fees, co-pays, and outstanding balances are due at the time of service; failure to collect such balances as a result of oversight or misinformation provided by the payer does not void or negate balances due and may be subject to additional late and collection fees. A $10 convenience fee will be charged for all uncollected co-pays.**

Preventative Medicine: Preventative medicine (such as physicals, well woman exams, and well child checks) is the part of medicine engaged with preventing disease rather than treating it. For the sake of thoroughness, during a preventative office visit, the providers at MY DR NOW prefer to defer treatment of other ailments or disease processes for a later office visit. **If other non-preventative issues are addressed at the time of a preventative visit, the applicable co-pays will need to be collected prior to being discharged from the facility. Preventative visits are only exempt from co-pays when the focus of the encounter is strictly preventative and does not in any manner address non-preventative complaints, concerns, issues, or refills.**

Office Visit Basics: **An office visit is comprised of an evaluation by a trained medical professional. An office visit in no way guarantees that any form of medication, treatment, referral, diagnostic study, doctors excuse, or any other request made by the patient will be granted. It is at the sole discretion of the provider to consider what is most prudent and requests for refunds will not be taken into consideration. MY DR NOW allows for a platform in which patient-provider interactions may occur; differing, conflicting, opposing, contradictory, inaccurate opinions and/or diagnoses do not negate or void balances due.**

Lab & Study Results: In order to minimize miscommunication of study results, details will be addressed with our patients during the time of an office visit. Specific details of lab and study results will not be discussed over the phone. In the event of an abnormal result, we ask our patients to come in for an office visit for interpretation of results, further evaluation, and to discuss the abnormal findings and treatment plan with a provider. You will receive a call from our office to provide you with instructions on *when* you should return. If you have questions or concerns about normal study results we invite you to come in for an office visit and have a provider interpret the results & discuss any remaining questions and/or concerns which you may have. There will be a charge for these visits.

Food & Eating: With the exception of bottled water, food is prohibited within the office.

Referrals & Prior Authorizations: The healthcare industry standard for the processing of referrals and prior authorizations is 14 days. At MY DR NOW we strive to beat industry standards in every aspect. Please allow 7-14 days for the processing of referrals and prior authorizations. We are our patient's biggest advocates, and we believe in attacking ailments and disease processes aggressively. The providers and staff at MY DR NOW work diligently to get approval for the studies and referrals we believe our patients need. Sometimes this process may take longer than we like, but please be patient as we work with your insurance company to get you the superior healthcare you deserve. Please also remember we are prohibited from completing referrals and prior authorizations on ailments for which you have never been seen and/or evaluated for here at MY DR NOW.

Phone Messages: A MY DR NOW patient representative will contact you within 24-48 hours of your office visit to ensure that all questions and concerns have been adequately addressed. We encourage and request that our patients ask questions and provide feedback; we also request that our patients contact us anytime they have questions or concerns about their care. Please allow 24-48 hours for a return call from one of our office staff when leaving messages. Please also remember that the providers at MY DR NOW are not able to refill medications, give any medical advice, or make changes to any treatment modalities over the phone. If your needs must be addressed sooner, please feel free to come in for an office visit any time during office hours.

Treatment of Minors: It is generally preferred that a parent or guardian accompany a minor at any office visit. There are however exceptions to this rule. Delivery of care will not be delayed while waiting for consent when evaluating a minor with an emergency condition. A minor is also allowed to give consent for the diagnosis and treatment of drug and alcohol related issues, contraceptive services, and for the treatment of sexually transmitted diseases. When appropriate, minor ailments may also be treated without the presence of a parent. Once again written or oral consent is preferred, but not mandatory, and this will be left up to the discretion of the office. Sports physicals however, require written consent when the parent is unable to accompany the child to the office.

Copies of Records: We are happy to provide you with copies of any and all of your medical records upon your request, we hope that you will be happy to know that we are a paperless office and eliminate waste whenever possible. To aid in this effort, we provide our patients with a personal electronic copy within 3 business days (72 hours) for a fee of $25. A personal electronic copy may be expedited within one business day (24 hours) for a $50 fee.

Forms & Letters: In order to provide patients with requested forms and letters in a timely manner, a charge to complete each individual and separately identifiable form will be assessed. If a provider must write a letter or fill out forms and documents on behalf of the patient, a flat fee will be required to complete the request. Please allow 3 business days (72 hours) for this process to be completed. All fees are due at the time of request.

- Forms $25
- Disability & FMLA paperwork $25
- Narrative Report $100

Medical & Doctor's Excuse of Absence: An excuse of absence will be granted by the provider based on medical necessity. If an extension is required for an excuse of absence, the patient will need to be re-evaluated with an additional office visit. An excuse of absence or an extension for an excuse of absence cannot be granted without an evaluation by a provider during an office visit.

Cell Phones: In consideration of the medical equipment which is used in the clinic, and other patients, we ask that you either turn off cell phones and pagers or use the vibrate setting when visiting MY DR NOW. **Please do not answer or talk on your cell phone while in the exam room.** This does interfere with the accuracy of EKG's performed in the office.

Pain Management: Pain is costly for individuals and society; an adult experiencing pain loses an average of 23 days of productivity per year. Moreover, pain can significantly affect the quality of life of an individual and cause disruptions in sleep, eating, mobility, and overall functional status. Furthermore, millions of Americans live with pain, and since pain management is an integral and important part of medicine, the providers at MY DR NOW believe *acute* pain should be managed appropriately. However, in order for our patient population to receive the best care possible, we recommend a pain specialist be utilized for the evaluation, management and treatment of chronic pain. To reiterate, we ***do not*** treat chronic pain at MY DR NOW.

Acute pain is defined as pain that has a recent onset, has a duration of less than 3 months, and subsides as healing occurs. **Chronic pain** is defined as pain that persists or progresses over a 3 month period, is often resistant to medical treatments, and may require a consistent dose of medication in order for the patient to remain functional. Please be aware that standard medical protocol states that pain management after surgery is best handled by the surgeon's office and not a primary care doctor. Some of the medications that MY DR NOW does not write for include, but is not limited to: Fentanyl, Dilaudid, OxyContin, Oxymorphone, Methadone, and Suboxone.

Disruptive Behavior & the MY DR NOW Code of Conduct: MY DR NOW's Code of Conduct defines disruptive behavior as anything that an individual might do which may (A) interfere with the orderly conduct of the clinic (B) interfere with the ability of others to effectively carry out their duties (C) interfere with patient care (D) undermine a patient's confidence in the facility or any member of the healthcare team (E) behavior and/or language which may be interpreted as being offensive, disrespectful, demeaning, abusive, combative, confrontational, or deemed to be inappropriate in any manner. MY DR NOW is fully committed to protecting its staff, providers, and patients against any form of disruptive behavior, and once the cornerstone of the doctor patient relationship is eroded the facility reserves the right to discharge the patient from the clinic permanently. MY DR NOW will aggressively pursue and litigate against any disparaging statements and/or behavior which may be deemed as defamatory, libel, or slanderous.

Pregnancy Tests: Please note that when urine studies are ordered by a provider, a pregnancy test will automatically be performed on all female patients of childbearing age regardless of past Gynecological, Obstetric, or surgical history.

NEW PATIENT INFORMATION

Your "Medical Home"

Last Name: _____ First: _____ Middle: _____

Nickname (if any): _____ Maiden Name: _____ Gender: ☐ M ☐ F SS#: _____

☐ Married ☐ Single ☐ Divorced ☐ Widow Date of Birth (DOB): _____ DL# & State Issued: _____

Race *(check or leave blank to decline)*: ☐ Am. Indian/Alaska Native ☐ Asian ☐ Black/African Am. ☐ Hawaiian/Pacific Islander ☐ White ☐ Other

Other family member(s) seen at MYDRNOW *(List name/DOB)* _____

Ethnicity *(check or leave blank to decline)*: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Preferred Language: _____

Permanent Address: _____ City: _____ State: _____ Zip: _____

Temporary Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Email: _____ ***Preferred Contact** (circle): Phone (H) Phone (C) Phone (W) Text Message Mail

INSURANCE INFORMATION

Primary Policyholder Information

Insurance Name: _____

Employer Name: _____

Employer Telephone: _____

Group#: _____ Policy #: _____

Policyholder: _____

Policyholder DOB: _____

DL#: _____ SS #: _____

Secondary Policyholder Information

Insurance Name: _____

Employer Name: _____

Employer Telephone: _____

Group#: _____ Policy #: _____

Policyholder: _____

Policyholder DOB: _____

DL#: _____ SS #: _____

FINANCIAL INFORMATION **Guarantor Information**

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Home/Cell#: _____ Work #: _____

Employer: _____

Guarantor DOB: _____

DL#: _____

SS #: _____

CONSENT TO DISCUSS MEDICAL INFORMATION AND RELEASE MEDICAL RECORDS

Name: _____

Relationship: _____

Name: _____

Relationship: _____

EMERGENCY CONTACT INFORMATION

1st Contact: _____ Phone: _____ Relationship: _____

2nd Contact: _____ Phone: _____ Relationship: _____

I hereby authorize MY DR NOW to leave messages regarding lab results and scheduled appointments: Patient Initials _____

I hereby authorize MY DR NOW to appoint _____ as my Primary Care Physician: Patient Initials _____

I have received, read, and understand MY DR NOW Clinic Policies: Patient Initials _____

I have received, read, and understand HIPAA Privacy Regulations: Patient Initials _____

FINANCIAL POLICY

Co-payments are due at the time of service for office visits including any follow up office visit(s). Co-pays are a contract between you and your insurance company, therefore, MY DR NOW is unable to waive them. Based on standard insurance and clinic guidelines, all payments, co-pays, and outstanding balances are due at the time of service. MY DR NOW accepts all major insurance plans; additional forms of payments include Cash, Debit Cards, MasterCard, Visa, Discover and American Express. As a service to you, MY DR NOW will process an insurance claim on your behalf. Not all insurance plans cover all services. In the event your insurance plan determines a service is not a covered benefit, you will be responsible for the entire charge. Payment for past due patient balances will be collected prior to obtaining additional services. To ensure all billing and financial matters are handled appropriately, MY DR NOW engages a third party agency to review and process all refund requests and therefore cannot issue refunds in the facility under any circumstances.

SELF-PAY PATIENTS

For all self pay patients, payment is due in full at the time of service. This includes payment for any ancillary services including labs, x-rays, immunizations, injections or procedures. At any time, if you choose to be seen as a self-pay patient, MY DR NOW will not be able to bill your insurance carrier for the cost of the office visit. The self-pay fees are only available for self-pay patients who pay in full at the time of service.

WORKER'S COMPENSATION CLAIMS

If the injury is not approved, your insurance cannot be billed and the services will be your responsibility.

RESPONSIBLE PARTY

I have read and understand **MY DR NOW**'s patient policies, and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time. I understand that I am responsible for all charges regardless of insurance coverage.

I agree to pay my account with **MY DR NOW** in accordance with the standard rates and payment terms of this office. I understand that I have provided all information including accurate and complete insurance information. If I do not provide all necessary information, it is my understanding I will be responsible for all charges incurred for any and all visits at **MY DR NOW**.

I understand that a ***monthly late fee of $10 will be assessed for all patient balances over 30 days old.*** If it is deemed necessary, in the sole discretion of this office, to take collection action as a result of nonpayment, I understand that any collection expenses incurred, including late fees, attorney's fees and contingency collection fees are my responsibility.

Signature _____ Date: _____

Last Name: _____ First:_____ DOB: _____

ALLERGIES

Please list any Known Allergies: _____

_____

_____

_____

_____

CURRENT MEDICATIONS

Please list any Medication/Dose/Frequency of Use you are currently taking: _____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY

Last Name: _____ First:_____ DOB: _____

Please check ALL boxes that apply, leave blank if you have never had symptoms. **PLEASE GIVE DETAILS OF AGE/ONSET ON LINES BELOW.**

☐ **History Unremarkable**

Allergy/ Immune System

☐ Seasonal Allergies
☐ Low Immune System
☐ Other_____

Blood Disorders

☐ Hemolytic Anemia
☐ Iron Deficiency Anemia
☐ Other_____

Cancers

☐ Bone Cancer
☐ Brain Tumor
☐ Breast Cancer
☐ Cervical Cancer
☐ Colon Cancer
☐ Lung Cancer
☐ Melanoma
☐ Ovarian Cancer
☐ Renal Carcinoma
☐ Skin Cancer
☐ Thyroid Cancer
☐ Other_____

Genetic

☐ Autism
☐ Developmental Delay
☐ Down's Syndrome
☐ Mental Retardation
☐ Multiple Sclerosis
☐ Other_____

Reproductive

☐ Endometriosis
☐ Erectile Dysfunction
☐ Polycystic Ovarian Disease
☐ Other_____

GI-(Gastrointestinal)

☐ Cirrhosis (liver)
☐ Colon Polyps
☐ Crohn's Disease
☐ Gallbladder Disease
☐ Hepatitis
Type_____
☐ Irritable Bowel Syndrome
☐ Pancreatitis
☐ Peptic Ulcer Disease
☐ Reflux (GERD)
☐ Stomach Ulcer
☐ Ulcerative Colitis
☐ Other_____

Heart

☐ Blood Clot
☐ Artery
☐ Vein
☐ Heart Attack
☐ Heart Failure
☐ Heart Valve Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Irregular Heart Beat
☐ Atrial Fibrillation

Heart (continued)

☐ Atrial Flutter
☐ Supraventricular Tachycardia
☐ Ventricular Tachycardia
☐ Ventricular Fibrillation
☐ Peripheral Vascular Disease
☐ Other_____

Hormone/ Endocrine

☐ Diabetes, type 1
☐ Diabetes, type 2
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Other_____

Kidney/ Urinary Tract

☐ Acute Renal Failure
☐ Chronic Renal Failure
☐ Kidney Stones
☐ Polycystic Kidney Disease
☐ Urinary Reflux
☐ Other_____

Lungs

☐ Asthma
☐ COPD
☐ Chronic Bronchitis
☐ Pulmonary Embolism
☐ Pulmonary Hypertension
☐ Other_____

Muscle/Bone/Tissue

☐ Chronic pain
☐ Fibromyalgia

Muscle/Bone/Tissue (continued)

☐ Gout
☐ Osteoarthritis
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Other_____

Nerve/Brain

☐ Alzheimer's Disease
☐ Stroke
☐ Dementia
☐ Headaches
☐ Parkinson's Disease
☐ Seizure Disorder
☐ Other_____

Skin

☐ Eczema
☐ Psoriasis
☐ Other_____

Other/ Miscellaneous

☐ Glaucoma
☐ Sleep Apnea
☐ Other_____

Hospitalizations

Reason:_____
Date:_____

Reason:_____
Date:_____

Reason:_____
Date:_____

PLEASE GIVE DETAILS OF AGE DIAGNOSED/ONSET OF CHECKED ITEMS ON LINES BELOW: _____

_____

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY

Last Name: _____ First: _____ DOB: _____

GYNECOLOGICAL HISTORY

Pregnancy

Total Pregnancies _____ Total Live Births _____

Number of Miscarriages _____ Number of Abortions _____

Problems with Pregnancy

- ☐ Gestational Diabetes
- ☐ High Blood Pressure- Pregnancy Induced _____
- ☐ Pre-term Labor
- ☐ Other _____

Problems with Cycles

- ☐ None
- ☐ Irregular Frequency/ duration
- ☐ Heavy Bleeding
- ☐ Other _____

Current Birth Control

☐ _____

Mammograms

- ☐ Never
- ☐ Last Mammogram was _____ (month/year)
- ☐ No History of Abnormal Mammogram(s)
- ☐ Positive History of Abnormal Mammogram(s)

Age at first Menstruation _____

Age at Menopause _____

PAP Smears

- ☐ Never Date of last PAP _____
- ☐ No History of Abnormal PAPs
- ☐ Positive history of Abnormal PAPs

SURGICAL HISTORY

- ☐ None
- ☐ Appendix Removed Date or age _____
- ☐ Breast Removed ☐ R ☐ L Date or age _____
- ☐ C-Section Date or age _____
- ☐ Gallbladder Removed Date or age _____
- ☐ Heart Stent Date or age _____

Location _____

- ☐ Hysterectomy Date or age _____
- ☐ Joint Replacement Date or age _____

What Joint _____

- ☐ Pacemaker Implantation Date or age _____
- ☐ Thyroid Removed Date or age _____
- ☐ Tonsils Removed Date or age _____
- ☐ Other List include date or age _____

_____

_____

_____

FAMILY HISTORY

☐ **FMHx Unremarkable** ☐ **FMHx Unknown**

List _____

_____

_____

_____

Advance Directives

☐ None ☐ Living Will ☐ On File

Date Signed _____

Durable Power of Attorney

☐ On File Date Signed _____

Do Not Resuscitate

☐ On File Date Signed _____

Organ Donation

☐ On File Date Signed _____

Other Document

Name _____

☐ On File Date Signed _____

Please list names of other doctors/specialists you are currently seen by:

_____

_____

_____

SOCIAL HISTORY

Pediatric/Adolescent

Parents' Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Unmarried ☐ Unmarried, Live Together ☐ Widowed/ Father Deceased ☐ Widowed/ Mother Deceased ☐ Other

Parent's Occupation

Mother _____

Father _____

Other Living Arrangements ☐ Is Adopted ☐ In Foster Care

Who is Primary Caregiver? _____

Members of Household

☐ Both Parents ☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Foster Parents

Siblings # of Sisters _____ # of Brothers _____

# of Step- Sisters _____ # of Step-Brothers _____

Tobacco Smoke Exposure ☐ No ☐ Yes

School/ Daycare _____

List grade and school _____

continued on next page

PAST MEDICAL HISTORY CONTINUED

Last Name: _____ First: _____ DOB: _____

SOCIAL HISTORY *continued*

Adult

Occupation _____

Place of Employment _____

☐ Self Employed ☐ Unemployed ☐ Homemaker

☐ Student Retired – Prior occupation _____

☐ Disabled – Disable due to _____

☐ Other _____

Marital Status

☐ Single ☐ Married ☐ Married (Common Law)

☐ Separated ☐ Divorced- # of times _____

☐ Divorced/ Remarried ☐ Widowed ☐ Widowed/ Remarried

☐ Other _____

Number of Children

☐ None Total Number of Children_____ Step-Children_____

Ages _____

Hobbies/ Recreation (basketball/ card games/ gardening etc.)

_____

_____

Exercise

☐ None ☐ Rarely

☐ Yes Type(aerobics,cycling,running _____

Frequency ☐ Daily _____ days/week _____ Min/Session

TOBACCO / ALCOHOL

☐ None

Tobacco ☐ Nonsmoker *(never smoked)*

☐ Current Use

☐ Cigarettes:_____cigarettes/day, _____years smoked

☐ Cigars:_____cigars/day, _____years smoked

☐ Smokeless Tobacco _____frequency

☐ Past Use

☐ Cigarettes-When did you quit? _____

☐ Cigars-When did you quit? _____

☐ Smokeless Tobacco-When did you quit? _____

Attempts to Quit: ☐ Never

☐ Once ☐ Successful ☐ Unsuccessful

☐ Twice ☐ Successful ☐ Unsuccessful

☐ Multiple Times ☐ Successful ☐ Unsuccessful

Alcohol

☐ Never ☐ Non-drinker

☐ Current Alcoholic ☐ in treatment ☐ not in treatment

☐ Past history of alcoholism - Time since last drink_____

☐ Current Drinker Quantity: _____drinks

Frequency: ☐ Rare ☐ Social ☐ Regular _____times/week

SUBSTANCE ABUSE HISTORY

Please list any prior or current substance abuse/use and date(s) of use.

Please include prescription and non-prescription substances.

_____

_____

_____

_____

_____

MENTAL HEALTH HISTORY

☐ Unremarkable ☐ Hospitalized for Mental Wellbeing

☐ Suicide Attempt ☐ ADD ☐ ADHD

☐ Anxiety ☐ Anorexia Nervosa ☐ Bipolar

☐ Bulimia Nervosa ☐ Dementia ☐ Depression

☐ Mental Retardation ☐ Obsessive-Compulsive

☐ Post Traumatic Stress Disorder ☐ Schizophrenia

☐ Other (inc. date or age diagnosed) _____

_____

_____

_____

_____

COMMUNICABLE DISEASE HISTORY

Sexually Transmitted Diseases

☐ Yes, but unknown type Date or age diagnosed_____

☐ AIDS/ HIV ☐ Chlamydia ☐ Gonorrhea

☐ Herpes ☐ HPV ☐ Syphilis

☐ Pelvis Inflammatory Disease ☐ Trichamonis

☐ Other (inc. date or age diagnosed)_____

_____

_____

_____

_____

Common Reportable Diseases

List _____

Date or age diagnosed _____

Rare Reportable Diseases

List _____

Date or age diagnosed _____

Environmental Exposures

List _____

Date or age diagnosed _____

NOTICE OF PRIVACY PRACTICES

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

OUR COMMITMENT TO YOUR PRIVACY

We understand that health information about you and your health care is personal. We create a record of the care and services you receive from MY DR NOW and are committed to protecting health information about you. We are required by law to **1)** Make sure health information that identifies you is kept private; **2)** Give you this notice of our privacy practices, and **3)** Follow the terms of the notice that is currently in effect.

ROUTINE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following categories describe the different ways in which we may use and disclose your protected health information (PHI).

- **Treatment**. We may use your PHI to treat you (i.e., laboratory tests, when we order or write a prescription for you). Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others outside MDN who are involved in your medical care.
- **Payment**. We may use and disclose your PHI to you, an insurance company, or a third party in order to bill and collect payment for the services you receive from us. This may include verifying your health benefits or providing information to obtain prior authorization.
- **Health Care Operations**. We may use and disclose your PHI to operate our business, i.e. we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. There are some services we may provide through our business associates.

OTHER USES

- **Appointment Reminders**. We may use and disclose your PHI to contact you and remind you of an appointment.
- **Treatment Options**. We may use and disclose your PHI to inform you of potential treatment options or alternatives.
- **Health-Related Benefits and Services**. Our practice may use and disclose your PHI to inform you of health-related benefits or services.
- **Release of Information to Family/Friends**. Our practice may release your PHI to a friend or family member that is involved in your care or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

We may use and disclose your PHI without your written permission when we are required to do so by federal, state, or local law, such as for law enforcement purposes, suspected abuse or neglect reporting, health oversights or audits, funeral arrangements, organ donation, public health purposes, or in an emergency.

OTHER USES OF HEALTH INFORMATION

We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us 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. Please note, we are required to retain records of your care.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

- **Confidential Communications**. You have the right to request that we communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the front office, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
- **Requesting Restrictions**. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. To request a restriction you must make your request in writing to Medical Records Department. Your request must describe in a clear and concise fashion 1) the information you wish restricted; 2) whether you are requesting to limit our practice's use, disclosure or both; and 3) to whom you want the limits to apply.
- **Inspection and Copies**. You have the right to inspect and obtain a copy of the PHI, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Medical Records Department in order to inspect and/or obtain a copy of your PHI. We may charge a fee for the costs of copying, mailing, and supplies associated with your request. We try to accommodate all reasonable requests; however if we deny your request to inspect and/or copy, you may request a review of our denial.
- **Amendment**. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made on our form *Request to Amend Medical Records* and submitted to Medical Records Department. You must provide us with a reason that supports your request for amendment. We will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that was not created by us, or is not part of the medical information maintained by us, or if the information is accurate and complete. If we deny your request, you can appeal our decision, in writing.
- **Accounting of Disclosures**. All of our patients have the right to request an accounting of disclosures made. This accounting will not include routine disclosures for treatment, payment, or health care operations purposes. In order to obtain an accounting of disclosures, you must submit your request in writing to Medical Records Department. The first list you request within a 12-month period is free of charge. We may charge you for additional lists within the same 12-month period. We will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
- **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. To obtain a paper copy of this notice, contact our Privacy Officer in writing.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our Officer Manager.

MINORS AND PERSONS WITH GUARDIANS

Minors and certain disabled adults are entitled to the privacy protection for their health information. Because by law, they cannot make health care decisions for themselves, a parent or guardian can make medical decisions on their behalf. Therefore parents or guardians can authorize the use and release of PHI and also hold all rights listed in this notice. Under certain situations defined by law, minors can make independent healthcare decisions without parent or guardian knowledge or consent. In those situations, the minor may hold all rights listed in this notice. If the minor chooses to inform the parent or guardian, then all privacy rights regarding PHI may transfer to the parent or guardian. There are also certain situations where access, use or release of a minor's PHI may occur without the consent of the parent or guardian, i.e. when the health or safety of the minor is in danger and PHI is necessary to protect the minor.

We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that we have created or maintained in the past, and for any we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.

Please direct any questions about this notice to our Privacy Officer at (480) 677-8282