

## Welcome to Primary Care Plus/O'Neal

Thank you for putting your trust in Primary Care Plus for your healthcare needs. We would like to take this opportunity to welcome you to our practice and look forward to providing you with personalized, comprehensive health care.

Having the most current information is essential in meeting your healthcare needs. We would appreciate your assistance in updating your medical record by completing the forms listed below:

- **Patient Information Form** - provides your physician with thorough knowledge of your current health issues, an accurate medication list, and a family medical history. Also includes your current contact information (phone number, email, text) so we can reach you regarding your healthcare.
- **Responsibility for Payment and Receipt of HIPAA Notice Form** – allows us to bill your insurance company for services provided to you and acknowledges you have received the Notice of Privacy Practices.
- **Consent for Treatment Form** - gives our medical staff permission to provide basic evaluation and treatment of your medical conditions.
- **Designation of Personal Representative Form** - grants a family member or friend permission to discuss medical or billing information on your behalf. Written permission is needed for us to discuss any aspect of your care with anyone else.
- **Authorization for Release of Protected Health Information**-allows us to obtain your medical records from other healthcare providers.

An important part of each visit with your doctor is reviewing all medications you are currently taking from ALL providers - both primary care and specialists. Please bring all medications with you to every visit.

Primary Care Plus is recognized as a Patient Centered Medical Home which is a reflection of our commitment to providing the highest quality care for our patients. We provide proactive care to promote wellness and prevent illness and will be communicating with you by telephone, text message (with your permission) and our patient portal. Please be sure to provide current contact information on the *Patient Information Form*.

As a patient of Primary Care Plus, we are committed to helping you *be well and enjoy life to the fullest*. Please review the additional information about Primary Care Plus that is in this folder. Should you have any questions or comments, please do not hesitate to contact me directly at **225-926-7200**

Sincerely,

Sandy Whittington  
Clinic Manager

Referred by: Name: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

## Patient Information Form (Please Print)

	Primary Care Physician:			Have you been a patient of Primary Care Plus or Stanocola in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b><u>PATIENT</u></b>  <input type="checkbox"/> Single  <input type="checkbox"/> Married  <input type="checkbox"/> Divorced  <input type="checkbox"/> Widowed  <input type="checkbox"/> Other	Last		First	MI	Date of Birth		Age
	Address				City	State	Zip
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female				Are you a student? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Street Address (if different from mailing)				City	State	Zip
	Phone (Home)		Name of Employer			Employer's Phone #	
	Phone (Mobile)		Employer's Address				
	Preferred Method of Contact? <input type="checkbox"/> Home Phone <input type="checkbox"/> Mobile Phone						
	May we send appointment and treatment reminders via text and voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	Email:						
	Spouse's Name				Date of Birth		
<b><u>ADDITIONAL INFORMATION</u></b>	Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Decline to Answer						
	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic			What Language do you prefer? <input type="checkbox"/> English <input type="checkbox"/> Spanish			
	Name of your Pharmacy			Address			
	City	State	Zip	Phone #			
<b><u>RESPONSIBLE PARTY</u></b>  <input type="checkbox"/> Self  <input type="checkbox"/> Spouse  <input type="checkbox"/> Guardian  <input type="checkbox"/> Other	Last		First	MI	Phone Number:		
	Address						
	City		State			Zip	
<b><u>IN CASE OF EMERGENCY NOTIFY</u></b>	Name				Relation		
	Address				Phone #		
<b><u>INSURANCE INFORMATION</u></b>	<u>Primary Insurance</u>			Address			
	Policy Contract #		Group #	City		State	Zip
	Name of Policy Holder			Date of Birth			
	<u>Secondary Insurance</u>			Address			
	Policy Contract #		Group #	City		State	Zip
	Name of Policy Holder			Date of Birth			

## PATIENT INFORMATION FORM

Patient's Name: \_\_\_\_\_ Guardian's Name (if under 18): \_\_\_\_\_

### ALLERGIES TO MEDICATIONS or ENVIRONMENTAL

<u>Medication or Other (Environmental)</u>	<u>Reaction</u>

### FAMILY HISTORY

(Please check if your family has a history of any of these diseases)

<u>Condition</u>	<u>Mother</u>	<u>Father</u>	<u>Maternal Grandparents</u>	<u>Paternal Grandparents</u>	<u>Brother</u>	<u>Brother</u>	<u>Sister</u>	<u>Sister</u>	<u>Additional Sibling(s)</u>
Cancer									
Diabetes									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Stroke									
Other									

If your mother, father, brothers, or sisters are deceased, please list their age at the time of their death and the cause:

<u>Relationship</u>	<u>Cause of death</u>	<u>Age at death</u>	<u>Relationship</u>	<u>Cause of death</u>	<u>Age at death</u>

### YOUR HEALTH HISTORY

(Check if you have had any of the following)

Abnormal Heart Rhythm	Chronic Pain	Heartburn/GERD	Obesity
Allergies (any)	Chronic Kidney Disease	Heart Murmur	Osteoporosis
Anemia	Depression	Hepatitis	Peripheral Vascular Disease
Anxiety/Stress	Diabetes	High Blood Pressure	Seizures/Epilepsy
Asthma	Emphysema/COPD	High Cholesterol	Sleep Apnea
Arthritis	Gallbladder Disease	HIV/AIDS	Stomach Ulcers
Atrial Fibrillation	Gout	Irritable Bowel Syndrome	Stroke
Colitis or Crohn's Disease	Headaches/Migraines	Kidney Failure	Thyroid Disease
Cancer	Heart Attack/Failure	Kidney Stones	

### PREVENTATIVE HEALTH HISTORY

Check if you have had any of the following preventative health screening exams (month/year)

<u>Test</u>	<u>Date</u>	<u>Results</u>	<u>Physician</u>	<u>Vaccine Type</u>	<u>Date</u>
Colonoscopy				Tetanus (Td)	
Cholesterol Screening				Pneumonia	
Cardiac Stress Test				Hepatitis B	
Bone Density				Influenza (Flu)	
Mammogram				Shingles	
Breast Exam				Other	

### OB/GYN HISTORY

Number of Pregnancies	
Number of full term babies	
Number of premature babies	
Number of abortions/miscarriages	
Number of living children	

### ACCIDENTS - TRAUMA:

Have you ever had a severe accident? **YES NO** Do you have any metal pins/plates in your body? **YES NO** If yes, please describe

**PAST SURGICAL HISTORY**

<u>Date</u>	<u>Surgery</u>	<u>Date</u>	<u>Surgery</u>

Please List Any Additional Medical Information:

\_\_\_\_\_

**HEALTH HABITS HISTORY**Do you now/have you ever smoked? YES NO (circle one) If yes, how long have/did you smoke? \_\_\_\_ How many packs per day? \_\_\_\_Did you quit? YES NO (circle one) If yes, what year did you quit? \_\_\_\_\_

How many alcoholic beverages do you drink per week? \_\_\_\_\_ How many days per week do you exercise? \_\_\_\_\_

In the past 6 months, have you had a regular problem with pain? YES NO Where? \_\_\_\_\_Do you wear glasses/corrective lenses? YES NO Do you wear a hearing aid? YES NO

Do you use any of the following equipment?

<u>Device</u>	<u>Yes/No</u>	<u>Device</u>	<u>Yes/No</u>	<u>Device</u>	<u>Yes/No</u>
Cane		Walker		Bi-pap (sleep apnea)	
Electronic Scooter		Wheelchair		C-pap (sleep apnea)	

Do you follow a healthy diet? YES NO (circle one) Please describe what type of diet you follow - well-balanced, low carb, low fat, etc.

\_\_\_\_\_

**LIST ALL PRESCRIPTION MEDICATIONS, VITAMINS, AND HERBAL SUPPLEMENTS**

<u>Name</u>	<u>Dose</u>	<u>Frequency</u>	<u>Ordering Provider</u>

**PHYSICIANS LIST**

(Please list any other physicians currently assisting in your care)

<u>Specialty</u>	<u>Physician</u>	<u>Specialty</u>	<u>Physician</u>	<u>Specialty</u>	<u>Physician</u>
Allergy/Immunology		Hematology		Pain Management	
Cardiology		Nephrology		Podiatry	
Chiropractor		Neurology		Psychiatry/Mental Health	
Dental		OB/GYN		Pulmonary Medicine	
Dermatology		Oncology		Rheumatology	
Endocrinology		Ophthalmologist		Sleep Medicine	
Gastroenterology		Optometrist		Urology	
General Surgery		Orthopedics		Other Specialty	

Do you have an advance directive/living will? YES NO (circle one)If yes, please supply the office with a copy for your chart. If no, would you like one? YES NO (circle one)

### **Responsibility for Payment/Receipt of HIPAA Notice/Patient Communication**

I understand that I am fully responsible for all fees due to Primary Care Plus or any associated medical provider (collectively referred to as the "Clinic") as a result of services I have received and that all fees are due and payable at the time of service unless Clinic agrees to accept assignment of my Medicare, Medicaid or other insurance benefits.

**If I have insurance coverage other than Medicare:**

I understand that assigning benefits to the Clinic and the filing of an insurance claim on my behalf is a courtesy to me and this is not absolving me of my responsibility to pay for services if the insurance company fails to pay for these services or if deductibles and/or co-pays are due. I understand that my insurance policy may not cover the full cost of services, or may consider it an uncovered service or medically unnecessary, or I may not have coverage benefits for these services. I therefore agree to be responsible for those charges incurred, as well as for my co-pay and/or any deductible that has not been met.

I further understand that any verification of my insurance benefits by the Clinic is not a guarantee of payment by my insurance company. If my insurance company does not pay for the services I have received, or fails to pay within 60 days of service, I understand that the Clinic will bill me for these services and I agree to pay any amounts due within 10 days of receipt of a bill for these services. In addition, if a claim is filed on my behalf as an unassigned claim, then I will also be responsible for the difference between the amount paid by my insurance company and the actual charge for that service.

**If I am covered under Medicare or a Medicare Advantage health plan :**

I understand that I will be responsible for my co-pay and/or any deductible that has not been met either through my Medicare coverage or any supplemental policy that I may also have. In addition, if a claim is filed on my behalf as an unassigned claim, then I will also be responsible for the difference between the amount paid by Medicare and the actual charge for that service.

I further understand that I will be notified in advance by an Advanced Beneficiary Notice of Noncoverage if Medicare likely will not pay for items or services. I will then have the right to make an informed choice whether or not to receive the items or services. If I choose to receive the items or services, I am aware that I will be responsible for paying for such items or services.

I request that payment of authorized Medicare, Medicaid or other insurance benefits be made on my behalf to the Clinic for any services furnished to me subject to any regulations pertaining to their assignment of benefits. I authorize any holder of my medical information to release to the Centers for Medicare & Medicaid Services, Social Security Administration and its agents, intermediaries or carriers, or to any other third-party sources or insurance companies and its agents any information or documentation needed to determine these benefits or the benefits payable for related services. A copy of this authorization may be used in place of an original and this authorization shall remain in force until revoked by me in writing.

I certify that the insurance information given by me is current and accurate to the best of my knowledge and I understand and agree to abide by the terms outlined above.

**I further acknowledge that I have received a copy of the Clinic's Notice of Privacy Practices.**

**I agree to receive appointment and treatment reminders via text and voicemail:** YES ☐ NO ☐

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Patient Name (Please Print)

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Date

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Patient or Responsible Party Signature

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Relationship to Patient

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Reason Patient Cannot Sign (if applicable)

## **Designation of Personal Representative**

As required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person(s) as your "personal representative." You may revoke this designation at any time by signing and dating the revocation section of your copy of this form and returning it to this office.

### **DESIGNATION SECTION:**

I, \_\_\_\_\_ Date of Birth \_\_\_\_\_ (print name and date of birth)  
hereby appoint the following person(s) to act as my personal representative(s) with respect to decisions involving the use and/or disclosure of health information that pertains to me.

**PRINT Name of Personal Representative(s)**

**PRINT Relationship of each to Patient**

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The Authority of this person when serving as my "personal representative" is restricted to the following functions:

Description:

- ☐ This person is to be afforded all of the privileges that would be afforded to me with respect to my health information.
- ☐ This person is restricted to the following information about my health care:

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to:

Primary Care Plus  
2645 O'Neal Lane  
Baton Rouge, LA 70816  
Attention: Clinic Manager

I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### **REVOCACTION SECTION:**

I hereby revoke the designation of \_\_\_\_\_ as my personal representative.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## **Consent for Treatment**

I, \_\_\_\_\_, am voluntarily seeking healthcare and hereby consent  
(Patient's name)

to medical treatment, procedures, laboratory tests and other health care services. I understand that I have the right to refuse specific treatments or procedures. However, by signing below, I agree in general, to permit laboratory and diagnostic tests, routine medical treatment (for example, medications, injections, drawing blood for tests, counseling, screening tests, health education and other diagnostic procedures), emergency procedures as necessary, and hospital services performed at the request of the attending physician or other physicians assisting in my care.

The consent given shall be valid and binding and the physician(s) can rely on this authorization and accept any consent given by the patient until such time as physician receives written notice that the authorization is revoked.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

## Authorization for the Release of Protected Health Information (PHI)

Patient Name (Last, First, Middle): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Contact Phone Number(s): \_\_\_\_\_

**I hereby authorize the following entity to release the Protected Health Information (PHI) below to:**

**Primary Care Plus, 2645 O'Neal Lane, Baton Rouge, LA 70816**

**Attention: Administration: Telephone: (225) 926-7200 Fax: (225) 706-2189**

Entity Possessing the PHI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_ Fax: \_\_\_\_\_

**If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.**

### PHI and Dates of PHI Authorized for Use of Disclosure

<u>Description</u>	<u>Start &amp; End Date of PHI</u>	<u>Description</u>	<u>Start &amp; End Date of PHI</u>
<input type="checkbox"/> All PHI Records	_____	<input type="checkbox"/> History & Physical Exam	_____
<input type="checkbox"/> Laboratory Test	_____	<input type="checkbox"/> X-Ray Tests/Reports	_____
<input type="checkbox"/> Progress Notes	_____	<input type="checkbox"/> Discharge Summary	_____
<input type="checkbox"/> Consultation Reports	_____	<input type="checkbox"/> Itemized Billing Statement	_____
<input type="checkbox"/> Other _____	_____		

**\*\*The following information will be released unless you indicate DO NOT RELEASE by checking the appropriate box**

☐ AIDS/HIV OR STD treatment    ☐ Psychiatric/Mental Care    ☐ Alcohol/Drug/Substance Abuse    ☐ Genetic Screening

Other, please specify: \_\_\_\_\_

### I understand that:

- I may refuse to sign this authorization and it is strictly voluntary.
- My treatment, payment, enrollment of eligibility of benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing to the provider authorized to release the PHI, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed.
- I have the right to receive a COPY of this form after I sign it.
- I will receive a photocopy only of my medical record and that the original will remain with Primary Care Plus

Signature of Patient or Patient's Representative (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative's Relationship to Patient and Description of Authority to Act: \_\_\_\_\_





ATTENTION: Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-504-681-8259.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-504-681-8259.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-504-681-8259.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-504-681-8259 an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。1-504-681-8259 にお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد.  
1-504-681-8259 تماس بگیرید.

**โปรดทราบ:หากคุณพูดภาษาไทย(Thai)**

มีบริการความช่วยเหลือด้านภาษาให้แก่คุณโดยที่คุณไม่ต้องเสียค่า

ใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข 1-504-681-5289.

Anumpa Pa Pisa: **Chahta (Choctaw)** anumpa ish anumpuli hokmvt tohsholi yvt peh pilla ho  
chi apela hinla.

! paya 1-504-681-5289

ગુજરાતી ભાષા: ગુજરાતી ભાષા સહાયતા સેવા (Gujarati) ગુજરાતી ભાષા સહાયતા સેવા સહાયતા  
સેવા

ગુજરાતી ભાષા સહાયતા સેવા સહાયતા સેવા.

ગુજરાતી ભાષા 1-504-681-5289 નાં નંબર નંબર.

توجه درکار ہے: اگر آپ اردو (**Urdu**) زبان بولتے ہیں تو آپ کے لئے زبان معاون خدمات دستیاب ہے۔ برائے مہربانی کال  
کری۔ 504-681-5289

हिन्दी भाषा: हिन्दी भाषा सहायता सेवा (Hindi) हिन्दी भाषा, हिन्दी भाषा सहायता  
सेवा, हिन्दी भाषा सहायता सेवा सहायता सेवा

हिन्दी भाषा 1-504-681-5289. हिन्दी भाषा सहायता सेवा

## Notice of Non-Discrimination

We<sup>1</sup> do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Primary Care Plus  
Attn: Privacy Officer  
3838 N. Causeway Blvd., Suite 2550  
Metairie, LA 70002  
Email: [info@primarycareplus.com](mailto:info@primarycareplus.com)

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call **1-504-681-8259** (TTY 711). We are available Monday through Friday, 8 a.m. to 5 p.m., CT

You can also file a complaint with the U.S. Dept. of Health and Human services.

**Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)

**Mail:** U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW  
Room 509F, HHH Building Washington, D.C. 20201

<sup>1</sup>For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices. Please note that not all entities listed are covered by this Notice.

## **Medical Information Privacy Notice**

Effective July 20, 2020

We<sup>2</sup> are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, and if we maintain a website, we will post a copy of the revised notice on our website [primarycareplus.com](http://primarycareplus.com). If we maintain a physical delivery site, we will also post a copy at our office. The notice will also be available upon request. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

### **How We Use or Disclose Information**

**We must** use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

**We have the right to** use and disclose health information for your treatment, to bill for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment.** We may use or disclose health information to obtain payment for health care services. For example, we may disclose your health information to your health plan in order to obtain payment for the medical services we provide to you. We may ask you for advance payment.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care. For example, we might analyze data to determine

how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, it is no longer subject to this notice and we may use it for any lawful purpose.

- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Reminders.** We may use or disclose health information to send you reminders about your care, such as appointment reminders with providers who provide medical care to you or reminders related to medicines prescribed for you.

**We may** use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved with Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and permitted by law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:
  1. Alcohol and Substance Abuse
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases;
  5. Genetic Information
  6. HIV/AIDS
  7. Mental Health
  8. Minors Information
  9. Prescriptions
  10. Reproductive Health
  11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not

using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out how to revoke an authorization, use the contact information below under the section titled "Exercising Your Rights."

### **What Are Your Rights**

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction other than with respect to certain disclosures to health plans as further described in this notice.**
- **You have the right to request that we not send health information** to health plans in certain circumstances if the health information concerns a health care item or service for which you or a person on your behalf has paid us in full. We will agree to all requests meeting the above criteria and that are submitted in a timely manner.
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests. In certain circumstances, we will accept your verbal request to receive confidential communications; however, we may also require you confirm your request in writing. In addition, any request to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as medical records and billing records. If we maintain a copy of your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect or obtain a copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as medical records and billing records if you believe the information is wrong or incomplete. Your request must be in writing and provide



the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.

- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on our website, [primarycareplus.com](http://primarycareplus.com) or 1-504-681-8259 (TTY 711).

### **Exercising Your Rights**

- **Contacting your Provider.** If you have any questions about this notice or want information about exercising any of your rights, please call 1-504-681-8259 (TTY 711).
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

Primary Care Plus  
Attn: Privacy Officer  
3838 N. Causeway Blvd., Suite 2550  
Metairie, LA 70002  
Email: [info@primarycareplus.com](mailto:info@primarycareplus.com)

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

**You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

<sup>2</sup> This Medical Information Notice of Privacy Practices applies to the following entity: Capital City Medical Group LLC d/b/a Primary Care Plus.