MEDFIRST
Primary & Urgent Care

Care for now. Care for life.

PATIENT INFORMATION SHEET

Location_____

Account # _____ Name of Employer: _____

First Name: _____ Middle Initial _____ Last Name: _____

Mailing Address: _____ Apt./Suite___City _____State ____ Zip_____

Home Phone: _____ Work Number: _____ Cell Phone Number: _____

Email Address: _____ Sex: ____ Marital Status: _____

Birth Date: ___ / ___ / _____ SSN: _____ / ____ / _____

Ethnicity: (check one) Hispanic or Latino_____ Not Hispanic or Latino_____ Declines to Respond_____

Race: (check one) American Indian / Alaskan Native_____ Asian_____ Black/African American_____

Native Hawaiian____ Other Pacific Islander____ White____ More than 1 Race____ Declines to Respond_____

Primary Care Provider_____

Preferred Language:_____Preferred Med First Provider_____

How Did Your Hear About Us? ☐ Word of Mouth - ☐ Billboard - ☐ Television Commercial - ☐ Google Search

☐ Referral - ☐ At An Event - ☐ Website - ☐ Direct Mail - ☐ Print Ad - ☐ Drove By Office - ☐ Other_____

You may need to fill out additional information

Emergency Contact: _____ Relationship: _____ Phone: _____

If Patient is a minor:

Guarantor Name: _____ Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Name of Employer: _____ Cell Phone: _____

Do you authorize Med First to obtain the last 13 months of your medication history from your insurance carrier and or pharmacy?

☐ Yes ☐ No

****To Process your Insurance Claim, you must complete this section****

Health Insurance Information:

Name of Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder / Sponsor Name: _____

Policy Holder / Sponsor Date of Birth: ___ / ___ / _____ Policy Holder Employer: _____

Policy Holder / Sponsor Social Security: _____ / _____/ _____

Policy Holder / Sponsor relationship to patient: _____

Do you have your insurance cards today? Yes / No

Assignment of Benefits: I hereby authorize Med First to examine me, including x-ray and procedures deemed appropriate by the treating provider if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my medical records to be held in strict secret confidence and not to be given to anyone without my written consent. I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by Med First Immediate Care. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal Law.

_____ ___ / ___ / ___

Patient / Representative Signature Date

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FAMILY PRACTICE HEALTH HISTORY QUESTIONNAIRE

Location_____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any questions, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THE QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Patient Name: _____ **Date of birth:** _____

Reason for today's visit: _____

Primary care physician: _____ **Preferred pharmacy:** _____

ALLERGIES

Please list anything you are allergic to (medication, food, bee stings, etc.) and how each affects you.

Allergy	Reaction
1.	
2.	
3.	

MEDICATIONS

Please list all the medications you are taking, Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Drug name	Strength	Frequency Taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		

FAMILY HEALTH HISTORY (Check all that apply, please specify type of cancers)

	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Father	Mother	Brother	Sister
Heart disease								
Cancer Type?⇨								
Diabetes								
Stroke								
Hypertension								
Depression								
Osteoporosis								
Other (please specify)								

IMMUNIZATION HISTORY (provide records if available)

☐ Pneumonia Date:_____ ☐ Flu Date:_____

☐ Zostavax (shingles) Date:_____ ☐ Tetanus Date:_____

Are you up to date on all of your childhood immunizations? **YES/NO** If not, please explain:_____

SOCIAL HISTORY

Current Occupation: _____

Education: ☐ less than 8th grade ☐ high school ☐ 2 year college ☐ 4 year college ☐ post grad

Marital status: ☐ married ☐ single ☐ divorced ☐ separated ☐ widowed

Do you have advanced directives? (living will) **YES/NO**

Exercise level: ☐ none ☐ occasional ☐ moderate ☐ heavy

Diet: ○ regular ○ vegetarian ○ vegan ○ gluten free ○ diabetic

Caffeine: ☐ none ☐ occasional ☐ moderate ☐ heavy

Alcohol: ☐ none ☐ < 3x a week ☐ > 3x a week ☐ heavy

Stress level: ☐ low ☐ medium ☐ high

Drugs: Do you currently use recreational or street drugs? **YES/NO**

If yes, please specify _____

Do you use tobacco? YES/NO

If not currently, did you ever use tobacco? **YES/NO**

- ☐ Cigarettes____ pks/day
- ☐ Chew_____/day
- ☐ Cigars_____/ day

# of year's_____ or year quit_____

PAST SURGICAL HISTORY

	Reason	Year	Hospital
1.			
2.			
3.			
4.			

OBSTETRIC AND GYNECOLOGICAL HISTORY

Age of first menstrual period:_____

Age at first child:_____

Date of last menstrual period or age of menopause:_____

Date of Last pap smear:_____

Date of last mammogram:_____

Number of pregnancies:_____ births_____ miscarriages_____ abortions_____

Cesarean sections? _____ If yes, how many?_____

Check all that apply:

- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Vaginal itching, burning or discharge
- ☐ Wake in the night to go to the bathroom
- ☐ Breast lump or nipple discharge
- ☐ Hot flashes
- ☐ Extreme menstrual pain
- ☐ Painful intercourse

SEXUAL ACTIVITY

Are you sexually active? **YES/NO**

Current sexual partner is: **FEMALE/MALE**

Do you use condoms? **YES/NO**

Interested in being screened for STD's? **YES/NO**

Are you currently using birth control? **YES/NO** If yes, please specify type_____

PAST MEDICAL HISTORY (Check all that apply)

- ☐ ADD or ADHD
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bedwetting
- ☐ Bleeding disorder
- ☐ Blood clots or DVT
- ☐ Blood diseases
- ☐ COPD
- ☐ Developmental or behavioral disorders
- ☐ Diabetes – Insulin
- ☐ Diabetes - non-insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Ear or hearing problems
- ☐ Eczema, hives or other skin conditions
- ☐ Erectile dysfunction
- ☐ Fibromyalgia
- ☐ GERD/reflux
- ☐ Gout
- ☐ Hospital admission (other than birth)
- ☐ High blood pressure
- ☐ Hyperthyroidism
- ☐ Hypogonadism
- ☐ Hypothyroidism
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Leg/foot ulcers
- ☐ Liver disease
- ☐ Muscle, joint or bone problems
- ☐ Cancer Type?
- ☐ Chicken pox
- ☐ Congenital abnormalities
- ☐ Constipation
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Pacemaker
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart problems
- ☐ Hiatal hernia or reflux disease
- ☐ High cholesterol
- ☐ Osteoporosis
- ☐ Pulmonary embolism
- ☐ Seizures/Epilepsy
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Vision or eye problems

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Location_____

Name:_____ **D.O.B.:**_____ **Date:**_____

Reason for Visit:

_____

_____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Cardiovascular
- ☐ Arm Pain on Exertion
- ☐ Chest Pain on Exertion
- ☐ Chest Heaviness/Pressure on Exertion
- ☐ Irregular Heart Beats (Palpitations)
- ☐ Known Heart Murmur
- ☐ Light-headed on Standing
- ☐ Shortness of Breath When Lying Down
- ☐ Shortness of Breath When Walking
- ☐ Swelling (edema)

Constitutional
- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain (____lbs)
- ☐ Weight Loss (____lbs)

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change

Date of Last Exam:_____

Ears/Nose/Mouth/Throat
- ☐ Bleeding Gums
- ☐ Difficulty Hearing
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems
- ☐ Ringing in Ears

Endocrine
- ☐ Fatigue
- ☐ Increased Thirst/Hunger/Urination

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Frequent Indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Incomplete Emptying
- ☐ Increased Urinary Frequency
- ☐ Urinary Loss of Control

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands

Integumentary (Skin)
- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growth/Lesions
- ☐ Itching
- ☐ Jaundice (Yellow Skin/Eyes)
- ☐ Rash

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Migraines
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Psychiatric
- ☐ Alcohol Overuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Do Not Feel Safe in Relationship
- ☐ Mania
- ☐ Sleep Problems

Respiratory
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

Please add any other information about your health that you would like your provider to know here:

_____

_____

_____

_____

_____ _____

Parent, Guardian, or Caregiver Signature Date

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Location_____

PROMISSORY NOTE

Name_____

Please choose your payment source

Private Pay:

I, _____ am acknowledging that I am a self paying patient seeking medical attention, I agree to pay my visit in full at the time of service and pay my remaining balance in full within 30 days or before my next scheduled appointment.

Insurance:

I, _____ acknowledge that my claim will be sent to my insurance carrier for reimbursement, I will be responsible for the remaining balance (if any) in accordance with my insurance plan. Such payments will be paid within 30 days of receipt of my statement.

Workman's Compensation:

I, _____ acknowledge that a claim will be filed with my workmans compensation carrier. If my claim is denied, I will be responsible for the charges n the account. Such payments will be paid within 30 days of receipt of statement. It is my responsibility to supply MFIC with the information needed to process any and all claims.

Personal Injury:

I, _____ acknowledge that a claim will be filed with my attorney, private insurance and/or claim adjustor. I will be responsible for all claims if payment is not received from the sources listed. Such payments will be paid within 30 days of receipt of statement. It is my responsibility to supply MFIC with the information needed to process any and all claims.

Signature of responsible party _____

Date ____ / ____ / ____

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Location_____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I. Patient's Name _____ DOB_____

Phone Number _____

If you want to allow others access to your personal health information please complete section II – IV otherwise proceed to section V

II. Please check one and provide the requested information:

_____ I hereby authorize the Med First Immediate Care & Family Practice and any of its Medical Providers to disclose my Protected Health Information to the following organization(s) and/or person(s):

Name: _____ Phone: _____ Fax: _____

Address: _____

III. I authorize the following information to be disclosed:

CHECK ONE	DATE(S)	
☐	_____	Complete Medical Record, including records from other providers and immunizations
☐	_____	Complete Medical Record while at Med First, not including records from other providers
☐	_____	GYN (Pap, Pelvic, Lab)
☐	_____	Lab
☐	_____	X-ray
☐	_____	Other or Relating to Particular Problem_____

IV. Purpose of the Requested Disclosure: Please check one and provide the requested information.

_____ At the request of the patient. _____(Patient's initials)_____

Other_____

(State specific purpose of requested disclosure)

V. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the Practice Manager or other health care provider identified in Section II above, as applicable. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that Med First Immediate Care & Family Practice may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that if the persons(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations. I understand that the information provided under this authorization may include Protected Health information which could contain diagnosis and treatment information including information pertaining to chronic and/or communicable diseases including but not limited to: alcohol or drug abuse; psychiatric or mental conditions; HIV or sexually transmitted disease; genetic disorders; and/or Sickle Cell.

Your provider and members of the practice staff may need to use your name, address, phone number, and you clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contract is made by phone and your not home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

I agree that a copy of this release or fax of this release shall be as valid as this original release. If I authorize Med First Immediate Care & Family Practice to fax the information, I realize there are inherent risks in faxing Protected Health Information.

This authorization expires upon_____

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to patient

Med First Immediate Care and Family Practice, PA

NOTICE OF PRIVACY PRACTICE AND PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME _____ **DATE** _____

I understand that under Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Med First Immediate Care and Family Practice, PA may use or disclose my protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Med First Immediate Care and Family Practice, PA has a detailed document called the ***"Notice of Privacy Practices"***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *"Notice"* before signing this agreement. If I ask, Med First Immediate Care and Family Practice, PA will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Med First Immediate Care and Family Practice, PA to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Med First Immediate Care and Family Practice, PA has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient (If signed by another party) _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*,
Including any revisions of our *"Notice"* at any time by contacting:

Med First Immediate Care and Family Practice, PA
609 Richlands Highway #6
Jacksonville, NC 28540
Or call 910-455-0052

MED FIRST

NOTICE OF PRIVACY PRACTICES

Effective Date: 01/01/2020

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice of Privacy Practices ('Notice'), please contact:

Privacy Officer: Gracie Williams
Phone Number: 910-455-0052

Section A: Who Will Follow This Notice?

This Notice describes Med First Immediate Care & Family Practice, PA (hereafter referred to as 'Provider') Privacy Practices and that of:

Any workforce member authorized to create medical information referred to as Protected Health Information (PHI) which may be used for purposes such as Treatment, Payment and Healthcare Operations. These workforce members may include:

- All departments and units of the Provider.
- Any member of a volunteer group.
- All employees, staff and other Provider personnel.
- Any entity providing services under the Provider's direction and control will follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for Treatment, Payment or Healthcare Operational purposes described in this Notice.

Section B: Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Provider. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or maintained by the Provider, whether made by Provider personnel or your personal doctor.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

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HIPAA Compliance Program

Section C: How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other Provider personnel who are involved in taking care of you at the Provider. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the Provider also may share medical information about you in order to coordinate different items, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the Provider who may be involved in your medical care after you leave the Provider.

- **Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the Provider may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at the Provider so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a prescribed treatment to obtain prior approval or to determine whether your plan will cover the treatment.

- **Healthcare Operations.** We may use and disclose medical information about you for Provider operations. These uses and disclosures are necessary to run the Provider and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Provider patients to decide what additional services the Provider should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health care students, and other Provider personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning a patient's identity.

- **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Provider.

- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- **Fundraising Activities.** We may use information about you to contact you in an effort to raise money for the Provider and its operations. We may disclose information to a foundation related

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to the Provider so that the foundation may contact you about raising money for the Provider. We only would release contact information, such as your name, address and phone number and the dates you received treatment or services at the Provider. If you do not want the Provider to contact you for fundraising efforts, you must notify us in writing and you will be given the opportunity to 'Opt-out' of these communications.

- **Authorizations Required**
  We will not use your protected health information for any purposes not specifically allowed by Federal or State laws or regulations without your written authorization, this includes uses of your PHI for marketing or sales activities.

- **Emergencies.** We may use or disclose your medical information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.

- **Psychotherapy Notes**
  Psychotherapy notes are accorded strict protections under several laws and regulations. Therefore, we will disclosure psychotherapy notes only upon your written authorization with limited exceptions.

- **Communication Barriers.** We may use and disclose your health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

- **Provider Directory.** We may include certain limited information about you in the Provider directory while you are a patient at the Provider. This information may include your name, location in the Provider, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. This is so your family, friends and clergy can visit you in the Provider and generally know how you are doing.

- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care and we may also give information to someone who helps pay for your care, unless you object in writing and ask us not to provide this information to specific individuals. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Provider. We will almost always generally ask for your specific permission if the researcher will

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have access to your name, address or other information that reveals who you are, or will be involved in your care at the Provider.

- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **E-mail Use.**
  E-mail will only be used following this Organization's current policies and practices and with your permission. The use of secured, encrypted e-mail is encouraged.

Section D: Special Situations

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs.

- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

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- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
    - in response to a court order, subpoena, warrant, summons or similar process;
    - to identify or locate a suspect, fugitive, material witness, or missing person;
    - about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
    - about a death we believe may be the result of criminal conduct;
    - about criminal conduct at the Provider; and
    - in emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Provider to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Section E: Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

- **Right to Access, Inspect and Copy.** You have the right to timely access to inspect, receive copies of and direct copies be sent to third parties of the medical information that may be used to make decisions about your care, with a few exceptions. Usually, this includes medical and billing records, but may not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- We may deny your request to inspect, receive or direct copies be sent of your medical information in certain very limited circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the Provider will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Provider. In addition, you must provide a reason that supports your request.

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- We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the medical information kept by or for the Provider;
    - Is not part of the information which you would be permitted to inspect and copy; or
    - Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an 'Accounting of Disclosures'. This is a list of the disclosures we made of medical information about you. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the accounting (for example, on paper or electronically, if available). The first accounting you request within a 12 month period will be complimentary. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply (for example, disclosures to your spouse). We are not required to agree to these types of request. We will not comply with any requests to restrict use or access of your medical information for treatment purposes.

  You also have the right to restrict use and disclosure of your medical information about a service or item for which you have paid out of pocket, for payment (i.e. health plans) and operational (but not treatment) purposes, if you have completely paid your bill for this item or service. We will not accept your request for this type of restriction until you have completely paid your bill (zero balance) for this item or service. We are not required to notify other healthcare providers of these restrictions, that is your responsibility.

- **Right to Receive Notice of a Breach.** We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

    - a brief description of the breach, including the date of the breach and the date of its discovery, if known;
    - a description of the type of Unsecured Protected Health Information involved in the breach;
    - steps you should take to protect yourself from potential harm resulting from the breach;

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- a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
- contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional Information.

In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our website or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or hard copy or e-mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you 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. You may obtain a copy of this Notice at our website. www.thinkmedfirst.com

To exercise the above rights, please contact the individual listed at the top of this Notice to obtain a copy of the relevant form you will need to complete to make your request.

Section F: Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice. The Notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register at or are admitted to the Provider for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current Notice in effect.

Section G: Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Provider or with the Secretary of the Department of Health and Human Services;
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

To file a complaint with the Provider, contact the individual listed on the first page of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Section H: Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by

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your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Section I: Organized Healthcare Arrangement

The Provider, the independent contractor members of its Medical Staff (including your physician), and other healthcare providers affiliated with the Provider have agreed, as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations. This enables us to better address your healthcare needs.

Revision Date: March 03, 2013, to be compliant with HIPAA Omnibus Privacy Rules.

Original Effective Date: April 14, 2003.

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No Show Fee Notice

Dear Valued Patients,

At Med First Primary & Urgent Care, our goal is to provide quality care in a timely manner. To ensure we can accommodate all of our patients effectively; we have updated our Missed Appointment Policy, effective April 1, 2025.

New Policy Details:

A $75 fee will be applied to your account for any missed appointment without prior notice. Patients who miss three (3) appointments within a 12-month period may be subject to dismissal from our practice. To avoid fees and ensure continuity of care, please provide at least 24-hour notice if you need to reschedule.

We understand that unexpected situations may arise, and we encourage you to communicate with us as soon as possible if you need to adjust your appointment. Your cooperation helps us serve you and other patients more effectively.

If you have any questions, or need to reschedule please contact our office or call center at 1-833-378-1071. Thank you for your understanding and support.

_____/_____

Patient Signature/Date