PEDIATRIC ASSOCIATES OF OCALA

Stephanie Shealy Harrell, M.D.
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2725 S.E. Maricamp Road
Ocala, Florida 34471
Phone (352) 369-8700
Fax (352) 369-8703
info@PAOcala.com
www.PAOcala.com

**********PRENATAL REGISTRATION**********

Due Date_____ OB/GYN_____

Hospital_____

Baby's Last Name First Name

_____

Do you have any other children that will be or are already seen in our office?_____
If yes, Please list their names.

Last Name **First Name** **M.I.** **DOB**

_____

_____

What insurance will your newborn be added to? _____

How were you referred to our office?_____

Do you know the sex of the Baby?__No / Yes If known please specify, Boy or Girl_____

Important Information for Expectant Parents:

- **Billing** - Most insurance companies allow 30 days to add a newborn to your policy. Please check with your insurance company and/or HR Department. If a newborn is not added within the 30 day period, they may not be covered under your insurance plan and all charges will be the member's responsibility in full.
- **Policy Benefits** - Once your baby is born, your insurance company will consider and cover the newborn as an individual under your policy. Depending on your specific plan, they may be subject to their own deductible and/or coinsurance amounts.
- **Vaccinations** –Prior to being discharged from the hospital, you will be asked if you want your baby to have his/her first Hepatitis B vaccine. This decision is 100% up to you. It can be given at birth. However, your baby will still receive 3 additional doses at our office starting at 2 months of age. If you have any further questions regarding this matter, please contact our office.
- **Circumcision** - If you wish to get your son circumcised, we recommend getting this done at the hospital if possible. If the hospital does not offer this procedure, don't stress. We have limited availability to do this procedure in the office and if time does not allow, we will refer you to a specialist.

*WE REQUIRE A $250.00 DEPOSIT FOR ALL CIRCUMCISIONS PERFORMED IN OFFICE BY OUR PHYSICIANS IF YOUR INSURANCE PLAN DOES NOT COVER THIS PROCEDURE.

*** Please see our circumcision form located on our website for more details****

PLEASE CHECK WITH YOUR SPECIFIC PLAN FOR COVERAGE INFORMATION AND PATIENT RESPONSIBILITY FOR THIS SERVICE.

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Would you like us to call you with an appointment date and time? Yes__ No__ Phone #_____

PATIENT REGISTRATION

(List all children)

Last name First name M.I. Sex D.O.B SS#

_____

_____

_____

_____

_____

Patient mailing address_____City_____ Phone#_____ State_____zip_____

Patient's school_____phone#_____

*Email for patient information purposes:_____

How did you hear about our office? _____

Pharmacy Address and Phone Number:_____

GUARANTOR INFORMATION

Patient's mother

Last name First name M.I. D.O.B SS#

_____

Address_____city_____st_____zip_____

Phone#_____ Cell Phone#_____

Employer_____phone#_____

Patient's father

Last name First name M.I. D.O.B SS#

_____

Address_____city_____st____zip_____

Phone#_____ Cell Phone#_____

Employer_____phone#_____

Guardian (if other than parent)

Last name First name M.I. D.O.B SS#

_____

Address_____city_____st____zip_____

Phone#_____ Cell Phone#_____

Employer_____phone#_____

Emergency contact not living with patient _____

Relationship to patient_____phone #_____

PLEASE SIGN AND INITIAL ALL NECESSARY PAGES

****All information must be filled out to enable insurance billing for payment****

***Preventive Care Appointments**
Our office follows the American Board of Pediatrics guidelines which requires all patients to receive annual preventive care visits and required immunizations. In these visits, the provider does a complete health examination. If wellness visits are reluctant to be scheduled or kept, this will result in the child and all siblings to be discharged from our practice.
Please note, Pediatric Associates of Ocala are only permitted to care for patients through the age of 18 years old under our medical malpractice insurance. _____***Initial***

***Vaccinations**
All patients of Pediatric Associates are required to receive the American Academy of Pediatrics recommended vaccines. (www.AAP.org) _____***Initial***

***Walk-In Visits and Late Appointments**
All visits require an appointment.
Unfortunately, under most circumstances, we are unable to see your child if you walk in without an appointment. You may be asked to return later in the day when the schedule allows. Please call the office to speak with our nursing staff or make an appointment. This will make sure that the provider has the appropriate amount of time to address your concerns.

Our office believes that everyone's time is valuable and we try to remain on time as much as possible. If you are running late or would like an additional child seen, please call the office so that we can provide the most appropriate accommodation.
Please note, if you are late 10 minutes or more, you may be asked to reschedule your appointment. _____***Initial***

***Canceled appointments**- As we do understand emergencies arise, please be courteous and cancel or reschedule your appointment at least 24 hours in advance. If you have an appointment that is "no call no show" you will be charged a $50.00 office appointment fee. Insurance plans do not reimburse this charge, and patients will be responsible in full.
Three or more missed appointments without notice will result in a discharge from the practice. _____***Initial***

***After Hours Phone Calls**
There will be a $30.00 after hours phone consultation fee for all calls made to the on-call provider after normal business hours. Insurance plans do not reimburse this charge, and patients will be responsible in full. This option is intended for emergency purposes. After regular office hours, you may reach the on-call provider at (352)369-8700 and press 2 (following our voicemail instructions). _____***Initial***

***Form and Letter Request Fee** *(One physical and vaccine record are given per year at your annual well child visit at no cost)*
Any form requiring a provider's signature and/or requiring provider documentation of medical information will be subject to a ***$5.00 form fee per page.*** Other forms/packets such as Patient Letter, Sports Physical form, Handicap form, 504 Plan forms, and FMLA forms are subject to a higher form fee due to the complexity of documentation needed. _____***Initial***

Fees for service**- ***Fees for services provided are due at time of service. If for any reason you are unable to pay upon checkout, you will be charged a $10.00 service fee in addition to the payment due at that time. I understand that my insurance company may require an authorization for services. If for any reason my insurance company does not give authorization for services incurred by the patient, I will be responsible for any and all charges. _____***Initial***

***Well and Sick / Same day Appointments**
When any patient is scheduled for a well appointment and is also seen for any unrelated issue, you may be subject to additional billing per your insurance for a sick visit on the same day.
It will be the member's responsibility if any copay, coinsurance, and/or deductible are applied. _____***Initial***

Selfpay**- Payment in full is expected at the time of service. _____Initial***

Medicaid**- it is the policy of our practice **NOT** to accept Medicaid as we are not contracted with these plans. Pediatric Associates does adhere to the Florida Medicaid Agreement and title 42 code of the federal regulation 447.20 and civil rights act of 1964. Due to this, we are unable to see any patient as selfpay if they have any form of Medicaid Insurance. _____Initial***

Insurance**- This practice participates with most insurance companies and will file a claim with your insurance carrier. You are expected to pay any deductibles, co-pays or percentages as required by your policy at the time of service. It is your responsibility to verify that Pediatric Associates participates with your insurance carrier and be aware of your specific plan benefits. If we are unable to verify benefits, you will be expected to pay in full at the time of service and we will provide you with the necessary receipt to file a claim to get your reimbursement. _____Initial***

Insurance denials**- If a claim is denied due to insufficient patient information or updated patient information required from you, the balance of the claim will be the patient's responsibility to pay in full, as well as, to contact your insurance company to correct the necessary information. Please note, due to the HIPAA laws and billing methods, insurances have begun to require all information for a patient (full name, address, date of birth, relationship to insured, and social security numbers) be included on a claim to verify the patient. If this information is not obtained, your claims may be denied and the balance will be patient's responsibility in full. _____Initial***

Financial Policy

Pediatric Associates is committed to providing you with the best possible care and will be pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions regarding our fees, financial policy or your responsibility

Release of information- I, the below named parent or guardian of the patient named below, do hereby authorize Pediatric Associates to release to any third-party payor or provider any and all medical information and records concerning diagnosis and treatment in connection with determining a claim for payment for such treatment and or diagnosis or when required by a third-party provider in the assessment, planning and or implementation of care.

Agreement

I agree that should the amount of insurance benefit be insufficient to cover the expenses, I will be responsible for payment of the difference. I will be responsible for the entire amount due (excluding disallowed amounts per a managed care contract) for services rendered if the expense is non-covered under the policy. I understand that Pediatric Associates will not become involved in disputes between me and my insurance company, regarding deductibles, co-payments, covered charges and or usual and customary charges other than to supply factual information as necessary.

The undersigned will pay all costs and expenses including a reasonable attorney fee incurred or paid by Pediatric Associates in the collection of this obligation by suit or otherwise the entire amount is due and payable upon billing.

This agreement shall remain in effect until revoked by me in writing; I also permit Pediatric Associates to use a photocopy of these assignments to be used in place of the original on file at Pediatric Associates.

Children of divorced parents- we do not become involved in disputes between parents and divorce decrees. The parent or guardian accompanying the child at the time of service will be responsible for payment.

I , the undersigned, have read and understand all policies and procedures of Pediatric Associates of Ocala listed above.

Parent or Guardian Signature_____ **Date**_____

PEDIATRIC ASSOCIATES OF OCALA

I, _____, have received a copy of the
(Please Print Name)
Notice of Privacy Practice by Pediatric Associates of Ocala and understand my rights according to the Health Insurance Portability and Accountability Act (HIPAA).

_____ _____
Parent/Guardian Signature Date

_____
Office Staff Witness

Please list all persons who we, Pediatric Associates, may speak with regarding any medical and/or financial information as well as anyone you may give permission to bring your child(ren) to their scheduled appointment(s). Thank you.

Name of Contact	Relationship to Patient(s)	Contact Number

PRIVIA HEALTH

Preferred Communication:
The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. **You may update or change this information at any time; please do so in writing.**

Patient Name: **Date of Birth:**

I prefer to be contacted in the following manner (check all that apply):

☐ **Send all communication through my Patient Portal.**

☐ **Home Telephone:**_____ ☐ **Cell Phone:**_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Work Telephone:**_____ ☐ **Written Communication:**_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Please send all of my mail to my home address on file
- ☐ Please send all mail to THIS address:

_____

_____

☐ **Other:**_____

My Preferred Contacts:

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

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

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

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

•**Name:**_____**Telephone:**_____**Relationship:**_____
Email::_____

•**Name:**_____**Telephone:**_____**Relationship:**_____
Email::_____

•**Name:**_____**Telephone:**_____**Relationship:**_____
Email::_____

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

Patient Signature: _____ **Date:** _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

PRIVIA HEALTH

Authorization and Consent to Treatment

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

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

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

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

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

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

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

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

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

Printed Name of Patient: **Email:** _____

Signature: _____ **Date:** _____

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

Name and Relationship of Person Signing, if not Patient: _____

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

PRIVIA HEALTH

HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name _____ Patient's Date of Birth _____

Address _____ Patient's Telephone Number _____

City, State Zip Code _____ Any Other Names Used _____

I request that my provider share my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all locations):
   _____
2. Be sent to the following person / entity at the address listed below: **PEDIATRIC ASSOCIATES OF OCALA**
   Name
   2725 SE MARICAMP ROAD 352-369-8700
   Address Telephone
   OCALA FL 34471 352-369-8703 office@paocala.com
   City State Zip Code Fax or Email Address for Delivery
3. I hereby authorize disclosure of the following information: ☒ My entire medical record ☐ Immunization Records Only ☐ Service Dates Only:
   _____ to _____ ☐ Specific Information Only:
   _____

NOTES

1. INFORMATION ABOUT ALCOHOL/SUBSTANCE USE, HIV/AIDS AND MENTAL HEALTH ISSUES IS INCLUDED UNLESS YOU SPECIFICALLY REQUEST THAT IT BE EXCLUDED IN THE SPACE BELOW. PSYCHOTHERAPY NOTES, HOWEVER, ARE NEVER INCLUDED.
2. IF YOU REQUEST WE SEND ONLY A PORTION OF YOUR RECORDS TO A TREATING PROVIDER, WE WILL SEND YOUR RECORDS TO YOU TO GIVE TO YOUR PROVIDER; **WE WILL NOT SEND INCOMPLETE RECORDS DIRECTLY TO A TREATING PROVIDER.☐ PLEASE *EXCLUDE* THE FOLLOWING INFORMATION:**
   _____ **Signature:** _____
3. I understand that I have the right to receive a copy of my PHI in the form and format and manner I request, if readily producible in that way, or as I may otherwise agree. **If I do not specify a format below, I understand that my PHI will be mailed to at the address listed above in hard copy/paper format. I hereby request that my PHI be provided in the following format:** ☐ via secure electronic delivery; **or** ☐ other (please specify)_____.
4. If I have requested records be sent unencrypted, I understand and acknowledge the risk of sending my PHI in an unsecured manner.
5. If I requested records be mailed to me, I understand I will be charged for the cost of paper and postage; if I request my records on a USB drive or similar, I will be charged the cost of that device.
6. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and will then no longer be protected by federal privacy regulations.
7. I understand I may revoke this authorization by notifying my provider OR privacy@priviahealth.com in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
8. I understand that my care and treatment may not be conditioned on providing this authorization, if such conditioning is prohibited by the HIPAA Privacy Rule.
9. My purpose/use of the information is for ☐ personal use; or ☐ other (please specify)_____.
10. This authorization expires on _____, 20___. OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please describe/specify event). If no expiration date is provided, this authorization will expire on one year from the date signed.
    _____.

NOTE: FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If these charges are expected to exceed $25, we will attempt to inform you prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

_____ **Signature of Patient**	_____ **Date of Patient's Signature**	_____ **Patient's Date of Birth**
_____ **If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate**	_____ **Date of Legal Guardian's/Personal Representative's Signature**	_____ **Description of Authority to Act for the Individual**

NEW PATIENT QUESTIONNAIRE – PEDIATRICS

Patient Name: _____ Date of Birth: _____
Reason for 1st appointment needed: _____
Questions or concerns you would like addressed at 1st appointment: _____
_____
Previous Physician: _____ City/State: _____
How did you hear about our office? _____

PAST MEDICAL HISTORY

Does your child *currently have* or *have been treated for* any of the following? (check all that apply)

	Diagnosis	Last Seen/Treated for		Diagnosis	Last Seen/Treated for
	ADHD/Behavioral Health			Sickle Cell Anemia	
	Allergies			Tuberculosis (TB)	
	Asthma			Seizures/Epilepsy	
	Reflux			Heart Disease	
	Noisy breathing			Lung Disease	
	Sleep Apnea			Kidney Disease	
	Hearing Loss			Meningitis	
	Ear Diseases			Bleeding Disorders	
	Cancer (Type: _____)			Transplant (Type: _____)	
	Other:				

HOSPITALIZATIONS (*please list*)

Date	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SURGERIES (*please list*)

Date	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT MEDICATIONS (*including vitamins, herbs, and over-the-counter*)

Name:	Dose:	Doing well on this Rx?		Issues/Concerns:
_____	_____	____Yes	____No	_____
_____	_____	____Yes	____No	_____
_____	_____	____Yes	____No	_____
_____	_____	____Yes	____No	_____

Do you have any **ALLERGIES TO MEDICATIONS**? ____Yes ____No
If yes, please list the medicine and describe the reaction: _____
_____

NEW PATIENT QUESTIONNAIRE (continued) – PEDIATRICS

FAMILY HISTORY (*Please check all that apply to your family members*)

___Allergy	___Asthma	___Cystic Fibrosis
___Ear Infections	___Hearing Loss/Deafness	___Bleeding Disorders
___Thyroid Disease	___Problems with Anesthesia	___Cancer (type:_____)

SOCIAL HISTORY

*Are your child's immunizations up to date? ___Yes ___No
*Is your child currently in daycare? ___Yes ___No
*Is your child exposed to tobacco smoke? ___Yes ___No
*Is there concern for suspected abuse, physical assault, sexual molestation/rape, domestic violence, unsafe living conditions, substance abuse or caregiver with psychiatric diagnosis in the home? ___Yes___No
*Does your child live in or regularly visit a home built before 1978 (lead risk purposes)? ___Yes___No
*In the past year, has your child been exposed to repairs, repainting, or renovations of a home built before 1978? ___Yes ___No

BIRTH HISTORY

*Was your child born prematurely? ___Yes ___No
If yes, by how many weeks? _____
*What was your child's birth weight? ___lbs ___ounces
*Has your child ever needed a breathing tube or ventilator? ___Yes ___No
*Did your child pass their newborn hearing screening test? ___Yes ___No
*Did your child have any problems at the time of delivery? ___Yes ___No

OTHER IMPORTANT MEDICAL INFORMATION NOT LISTED ON THIS QUESTIONNAIRE:

_____
_____
_____
_____
_____

Questionnaire completed by:

_____

Signature ***Relationship to Patient*** ***Date***

FOR OFFICE USE ONLY

_____

Physician Acknowledgement Date

INSURANCE VERIFICATION

PLEASE FILL OUT THE TOP PORTION OF THIS FORM OR ATTATCH A COPY OF THE PATIENTS INSURANCE CARD FRONT AND BACK.

Patient Name_____ DOB_____

Insured Name_____ Relationship to Patient_____

Insured employers name and address_____

Insurance Carrier Name_____

Managed Care Network_____

Address and Telephone # to send claims to_____

_____.

Policy ID#_____ Group#_____

****

FOR OFFICE USE ONLY

Effective Date_____

Date_____Auth By_____
Date_____Auth By_____
Date_____Auth By_____
Date_____Auth By_____
Date_____Auth By_____
Date_____Auth By_____
Date_____Auth By_____

WCC

Covered Yes_____ No_____

Deductible_____ Met_____ Then Pd %_____

Does deductible apply to WCC_____ Copay_____

Max allowed per year_____ Vaccines Covered Yes_____ No_____

Prevnar Covered Yes_____ No_____ Behavioral Health Covered Yes_____ No_____

Hearing Testing Covered Yes_____ No_____ (CPT code 92583 or 92551)

Vision Testing Covered Yes_____ No_____ (CPT code 99173)

SICK

Covered Yes_____ No_____

Deductible_____ Met_____ Then Pd %_____

Does deductible apply to sick visits Yes_____ No_____ Copay_____

Does deductible apply to labs, x-rays, and in-office procedures Yes_____ No_____

Does patient have Health Savings Account? Yes / No Remaining Funds? _____

PRIVIA HEALTH

FINANCIAL POLICY

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

PATIENT RESPONSIBILITY

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

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

INSURANCE

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

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

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

NO SURPRISES ACT / GOOD FAITH ESTIMATE OF CHARGES

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

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

CARD-ON-FILE PROCESS

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

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

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

YOUR RESPONSIBILITIES

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

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

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

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

No-shows. If you miss your appointment, you may be charged a $50.00 fee for a missed appointment, a $75.00 fee for a missed pediatric appointment, a $100.00 fee for a missed physical, or a $200 fee for a missed procedure or surgery. This fee will need to be paid before you are allowed to schedule another appointment. This fee cannot be billed to insurance.

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

Additional information about our financial policies is available on our website at priviahealth.com.

Thank you for choosing us as your healthcare provider!

PRIVIA HEALTH

Notice of Privacy Practices

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

A. OUR COMMITMENT TO YOUR PRIVACY

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

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

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

B. PERSONS/ENTITIES COVERED BY THIS NOTICE

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

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

C. CONTACT FOR QUESTIONS

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

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

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

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

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

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

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

5. Treatment Options and Health-Related Benefits and Services. Privia may use and disclose your PHI to inform you of treatment options or alternatives as well as certain health-related products, benefits or services that may be of interest to you. Privia may also use and disclose your PHI to provide you with information about payment for such products, benefits or services, including payment that might be available to you through your benefit plan. Privia may also use or disclose your PHI to offer information on other providers participating in a healthcare network in which Privia participates. In addition, Privia may use or disclose PHI to have communications sent to Privia's patients about certain government and government-sponsored programs including the Medicare Advantage and Medicare Part D Prescription Drug programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. YOUR PRIVACY RIGHTS REGARDING YOUR PHI

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

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

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

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

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

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

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

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

9. Right to File a Complaint. If you believe your rights have been violated, you may file a complaint with us or with the Secretary of the

Department of Health and Human Services ("HHS"), Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

G. ADDITIONAL INFORMATION

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

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

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

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

5. Substance Use Disorder Records and Information. The confidentiality of patient records maintained by federally assisted substance use disorder rehabilitation programs is protected by Federal law and regulations. Generally, such programs may not disclose any information that would identify an individual as having or being treated for a substance use disorder unless:
a. the individual consents in writing;
b. the disclosure is allowed by a court order;
c. the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; or
d. as otherwise permitted by law.

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

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

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

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

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

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

How does HIE Help You?

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

- **Improved Care** - Access to information about your health history and medical care gives your healthcare provider a more complete picture of your overall health. This can help your provider make better decisions about your care. The information may also prevent you from having repeat tests, saving you time, money and worry.

- **Emergency Treatment -** In an emergency, your providers may immediately check to see if you have allergies, health problems, test results, medications or previous concerns that may help them provide you with emergency care.
- **Helps to Protect Privacy and Information Security -** By sharing information electronically through a secure system, the risk that your paper or faxed records will be misused or misplaced is reduced.

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

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

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

You have choices about participating in HIE.

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

Choice 1: Say Yes. No further action needed.

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

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

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

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

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

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

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

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

If you have any questions about HIE, you can email privacy@priviahealth.com. To opt-out of HIE, please email medicalrecords@priviahealth.com.

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

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

Privacy Officer
950 N Glebe Rd, Suite 700
Arlington, VA 22203
(855) 541-9048 (toll free)
or email privacy@priviahealth.com

You can file a complaint directly with the **U.S. Department of Health and Human Services Office for Civil Rights** by sending a letter to:
200 Independence Avenue, S.W
Washington, D.C. 20201
calling 1-877-696-6775
or online at: www.hhs.gov/ocr/privacy/hipaa/complaints/

If your provider is licensed in Texas, you can also file a complaint with the **Texas Department of State Health Services Investigations:**
P.O. Box 141369
Austin, Texas 78714-1369.

More information is at: dshs.texas.gov/hipaa/privacycomplaints.shtm

We may not retaliate against you for filing a complaint.

Privia Notice of Privacy Practices Effective August 2023