



New Patient Packet - Huntsville, AL

Thank you for making your first appointment with AllerVie Health!

AllerVie Health and our Board-Certified Allergists and Immunologists are committed to helping patients achieve and maintain optimal health and quality of life -- free from the symptoms and suffering of allergies, asthma, and related immunological conditions.

Please complete the new patient packet following this letter, and bring it along with your insurance and driver's license to your first appointment. Please keep in mind that your first appointment can be lengthy due to the extensive information you will be provided to assist you in managing your continued good health.

Here are a few things to know for your first appointment:

- **Discontinue all Antihistamines FIVE days prior to your appointment.** Common medications containing Antihistamines are Benadryl, Triaminic, cough and cold medicines. Do not stop taking Singulair or asthma inhalers. For a complete list, visit allervie.com and click on **For Patients**.
- Please wear clothing that will allow allergy testing with ease. A two piece outfit, ex., shirt and pants work best.
- We love children! However, if you are being allergy tested you will need to remain stationary and it will be difficult to keep an eye on small children.
- We have Wi-Fi available in most locations for your convenience.
- Your visit as a new patient can last up to a few hours depending on testing needs. Please be prepared to stay at our office for the duration of your visit.
- **Remember that in order to be tested on the day of your initial visit you will need to discontinue certain medications five days prior to your appointment.** If you are concerned or have questions about which medications to discontinue, please do not hesitate to call our office.

Should you need to cancel or reschedule your appointment, please contact our office 24 hours before your appointment to avoid any cancellation fees, up to \$50.

We look forward to serving you and helping you find relief from your allergy symptoms!

Sincerely,
The AllerVie Health Team

Thank you for choosing our practice. We are committed to providing you with quality and affordable healthcare. Below is information regarding our privacy policy, consent for treatment and payment policy as it relates to patient and insurance responsibility for services rendered. Please review it, then sign/accept in the space provided. A copy will be provided to you upon request. If you have any questions please feel free to contact our office. Thanks so much for being our patient.

Acknowledgment Form for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge the use or disclosure of my Protected Health Information (PHI) by AllerVie Health, its Subsidiaries, and Partners for the purpose of diagnosing and providing treatment, obtaining payment, or conducting healthcare operations of AllerVie Health. I understand that diagnosis or treatment by the healthcare providers of AllerVie Health may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my Protected Health Information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. AllerVie Health is not required to agree to the restrictions that I may request. However, if AllerVie Health agrees to a restriction that I request, the restriction is binding on AllerVie Health and Healthcare Providers of AllerVie Health. I have the right to revoke this consent, in writing, at any time, except to the extent that AllerVie Health or Healthcare Providers of AllerVie Health have taken action in reliance on this consent prior to my withdrawal.

“Protected Health Information” means health information, including demographic information, collected, created, or received by my healthcare provider, another healthcare provider, a health plan, my employer, or a healthcare clearinghouse. This protected health information relates to past, present, or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may be able to be used to identify me.

The Notice of Privacy Practices for AllerVie Health has been provided via electronic access and can be provided in paper format, upon request. I understand I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur to ensure treatment, insurance collection, and performance of collaborative healthcare operations of AllerVie Health.

AllerVie Health reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by reviewing the notices provided online on AllerVie's main website or by requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Authorization and Consent for Treatment

Whether signing as an agent or as a patient, the undersigned agrees that in consideration of agreed upon services to be rendered by AllerVie Health to the patient, including allergy extracts and injections, the patient and representatives hereby obligates themselves, assuming financial responsibility, and agreeing to AllerVie Health's payment policy as outlined below regarding all charges for such services incurred by the patient. The undersigned consents to treatment as determined and discussed with their AllerVie provider and agrees to provide accurate medical histories and participate in health assessment and treatment. The undersigned also specifically agrees that AllerVie Health can use PHI to communicate via phone, email, or text for essential follow up needs, appointment reminders, care coordination, as well as conduct analysis for internal business purposes, customize patient needs for services, and create de-identified information to use and disclose in any way permitted by law, including to third parties in connection with commercial and marketing efforts. This office will file and collect from insurance when insurance benefits are present. I hereby authorize AllerVie Health to use “Signature on File” in lieu of an original signature for all medical claims submitted for services rendered to patient. I acknowledge that all information regarding my identity is correct and accurate to my knowledge. By signing/accepting this document I understand that I am held accountable for any false information which could result in a fine or penalty and should notify AllerVie Health if any of my information should change or if my identity is compromised or stolen.

Payment Policy

ALL DEDUCTIBLES, CO-PAYMENTS, AND CO-INSURANCE ARE DUE AT THE TIME OF SERVICE

Proof of Insurance/Claims Submission: AllerVie Health must obtain a copy of a patient's driver's license and current valid insurance to provide proof of insurance. We participate with most insurance plans and will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with your insurance company's requests. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company so any issues with denial should be directly addressed with your insurance company.

Referrals: If you have an insurance plan with which AllerVie Health is contracted, you may need a referral authorization from your primary care physician/pediatrician. Please ensure all required referrals are sent to AllerVie at a minimum of 24 hours prior to your visit. If we have not received a referral at least 24 hours prior to your arrival at the office, your appointment may be rescheduled.

Labs: All lab work is performed by outside reference labs. AllerVie Health does not verify benefits and coverage on lab services. Patients will receive a bill directly from the lab regarding any balances after insurance is filed. Please reach out to the lab and/or your insurance company for billing issues and/or questions related to lab billing.

Co-payments and Deductibles: All co-payments, deductibles, balances, and co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Methods of Payment: AllerVie Health accepts payment by cash, check, Visa, MasterCard, American Express, and Discover.

Patient Statements: If you have an unpaid balance, you will receive a statement by mail or email monthly. The statement amount is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 90 days will be turned over to an attorney or collection agency for collections. All payments made go to the oldest outstanding balance.

Self Pay: We accept self-pay for our services at select AllerVie locations. If you are uninsured or wish to self-pay for our services, we will also provide financial counseling for you at your appointment. Payment is due in full at the time of service.

No Show Fee: Should you need to cancel or reschedule your appointment, please contact our office at least 24 hours before your appointment to avoid any cancellation fees, up to \$50.

By accepting the terms outlined above I understand that all bills are payable upon presentation, and that I, not the insurance company, is ultimately responsible for payment of the services.

Signature and Acceptance

I understand that selecting Agree and entering name/initials via portal, or signature below constitutes a legal signature confirming that I acknowledge and agree to the above policies set forth by AllerVie Health.

Patient or Legal Guardian/Responsible Party Signature

Printed Name

Date

Relation to Patient (if applicable): _____

Medications to Hold for Testing

Prescription Antihistamines

- Atarax, Vistaril (hydroxyzine)
- Allegra (fexofenadine)
- Clarinex
- Periacin (cyproheptadine)
- Rondec
- Pediatex
- Pedi-Ox
- Rynnatan
- Q-DAL
- Tussionate
- Tussi-12
- Tannihist
- Xyzal
- *Doxepin/Adapin/Sinequan will need to be held longer than 5 days, but DO NOT STOP it until you have seen the allergist

Over-the-Counter Antihistamines

- Claritin, Alavert, Triaminic, Allerchews, Store Brand Non-Sedating Antihistamine (loratidine)
- Zyrtec (ceterizine)
- Benadryl (diphenhydramine)
- Tavist (clemastine)
- Chlorpheniramine (Like Chlor-Trimeton, Actifed, Allerest)
- NyQuil, Robitussin Night Cold, Tylenol Flu Night Time (doxylamine)
- Tylenol or Advil PM (contain diphenhydramine)
- Dramamine (dimenhydrinate)
- Anything that contains loratadine
- Anything that contains diphenhydramine
- Anything that contains brompheniramine
- Anything that contains chlorpheniramine
- Anything that contains carbinoxamine
- Anything that contains doxylamine
- Anything that contains clemastine
- Anything that contains tripolidine
- Anything that contains tripeleminamine
- Any "Allergy" or "Cold" Preparation (like Tylenol Cold & Sinus or Advil Cold & Sinus)

Other Types of Medications to Hold 5 Days Before Allergy Testing

Anti-Nausea Medications

- Dramamine (dimenhydrinate)
- Doxylamine
- Antivert, Bonine (meclizine)
- Phenergan (promethazine)

Over-the-Counter Sleep Aids

- Any "PM" Product (Like Tylenol PM or Excedrin PM or Alka Seltzer PM or Doan's PM)
- Simply Sleep Nighttime Sleep Aid
- Sominex
- Anything that contains diphenhydramine Nasal and Eye Drops to Hold 48 Hours Before Allergy Testing

Prescription Nasal Sprays

- Astelin Nasal Spray

All Over-the-Counter Eye Drops

- Visine A Eye Drops
- Op-Con A
- Naph-Con A
- Alomide Eye Drops

Prescription Eye Drops

- Patanol Eye Drops
- Zaditor Eye Drops
- Optivar Eye Drops
- Elestat Eye Drops

Medicines That You MAY CONTINUE & Should Not Interfere With Testing

- Saline Nose Spray
- Steroid Nose Sprays
- Afrin Nose Spray
- Singulair
- Asthma Inhalers
- Asthma Nebulizer Treatments
- Nasalcrom
- Crolom
- Zycam
- Mucinex (guaifenesin)
- Cough or Sinus Preparations that only contain dextromethorphan and/or guaifenesin and/or pseudoephedrine
- Plain Sudafed (pseudoephedrine)
- "Non-Drowsy" Cold Preparations EXCEPT NO LORATIDINE

PLEASE DO NOT TAKE ANTIHISTAMINES 5 DAYS PRIOR TO YOUR APPOINTMENT

Patient Information

First Name: _____ Last Name: _____

Middle Name: _____ Suffix: _____

Mailing Address: _____

City, State, Zip: _____

Residential Address (If mailing address is a PO Box): _____

City, State, Zip: _____

Preferred Phone: _____ Alternate Phone: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female ☐ Other Social Security #: _____Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed Age: _____

Patient's Employer: _____

How did you hear about our practice? _____

E-Mail Address: _____

Race: _____ Ethnicity (check one): ☐ Not Hispanic ☐ Hispanic

Preferred Language: _____

Referring Physician's Name: _____ Telephone #: _____ Fax #: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Responsible Party InformationName: _____ ☐ Spouse ☐ Parent ☐ Guardian's

Mailing Address: _____

City, State, Zip: _____

Preferred Phone: _____ Alternate Phone: _____ Date of Birth: _____

Social Security #: _____

Employer: _____

Emergency Information

Contact Name: _____ Relationship: _____

Phone Number: _____

Patient Account #: _____

Medical Insurance Information

Primary Coverage

Company Name: _____

Contract (ID) #: _____ Group #: _____

Name of Policyholder as it appears on card: _____ Relationship to Patient: _____

Address of Policyholder: _____

Date of Birth: _____ RX BIN #: _____

Secondary Coverage

Company Name: _____

Contract (ID) #: _____ Group #: _____

Name of Policyholder: _____ Relationship to Patient: _____

Address of Policyholder: _____

Date of Birth: _____

The undersigned agrees, whether he/she signs as agent or as the patient, that in consideration of services to be rendered by AllerVie Health to the patient named above, he/she hereby obligates himself/herself, assumes financial responsibility, and agrees to pay upon demand to provider all charges for such services and incidentals incurred by said patient. Should the account be referred to an attorney/collection agency, the undersigned agrees to pay 33% of the unpaid balance for collection costs or the maximum lawful fee, at such time the account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees, as may be determined by the court. The undersigned understands that all bills are payable upon service and that he/she, not the insurance company, is responsible for the payment of all services.

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any services and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

I hereby authorize AllerVie Health to use "Signature on File" in lieu of an original signature for all medical claims submitted for services rendered on above patient.

Signature of Responsible Party: _____ Date: _____

Printed Name of Responsible Party: _____

1. Name: _____ Sex: ____ Age: _____ Date of visit: _____
 Referred by / Primary Physician: _____ Weight: _____ Height: _____

CHIEF COMPLAINT(S): *Circle the type of problem(s) for which you seek an evaluation*

Nasal allergies, Asthma, Eczema, Chronic cough, Chronic hives, Food allergy, Drug allergy, Reaction to insect sting, Other

NASAL ALLERGY (nose / sinus / eye) symptoms

ASTHMA (chest) symptoms

2. How long have you had hay fever symptoms ? _____ yrs / mths 3. How long have you had asthma symptoms ? _____ yrs / mths

(CHECK THAT APPLY)	none	mild	Mod	severe	(CHECK THAT APPLY)	none	mild	Mod	Severe
a) Runny nose					a) Cough +/- Phlegm				
b) Sneezing					b) Wheezing				
c) Nasal congestion					c) Shortness of breath				
d) Post nasal drip					d) Chest tightness				
e) Red, itchy & watery eyes					e) Symptoms with exercise				
f) Itchiness of nose					f) Lump in the throat				
of throat					g) Choking, Loss of speech				
of palate					<u>SKIN (Eczema / Hives)</u>				
of ears					4. How long have you had skin symptoms? _____				
g) Sinus headaches					(CHECK THAT APPLY)	none	mild	mod	Severe
h) Impaired taste / smell					a) Hives (Urticaria)				
i) Post nasal drip cough					b) Swellings (Angioedema)				
j) Sinus infections					c) Eczema / Dry skin				

Answer question #5 if you have asthma symptoms. If not skip to question #6

5. =How often do you have asthma symptoms? Always Daily >2 x per week <2 x per week sporadic Other _____
 =Do asthma symptoms wake you up at night? YES / NO if yes, how many times a month / week _____
 =Number of asthma flare visits (specialist or primary care or walk-in clinic) in the past 12 months _____
 =Number of Emergency Room visits for asthma flare in the past 12 months _____
 =Ever hospitalized for asthma? YES / NO Number of hospitalizations? _____ Last hospitalization _____
 =Number of times on oral steroid courses (e.g.; Prednisone, Medrol, Decadron, Steroid shots) in the past 12 months _____
 =How many days of work or school have you missed due to asthma in the past 12 months _____
 =Do you monitor peak flows at home? YES / NO. If so, what is your ideal peak flow? Morning _____ Evening _____
 =Do you have stomach reflux symptoms (sour belching, heartburn, pain or difficulty swallowing) YES / NO

6. Do your symptoms vary with the seasons? YES / NO

If YES, place an "X" in the boxes when symptoms are worse

Symptoms	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Hay fever												
Asthma												
Eczema												
Hives												

7. Are you up to date on routine childhood vaccinations (immunizations)? YES / NO
 Flu vaccine received: YES / NO when? _____ Pneumococcal vaccine received: YES / NO when? _____
 (Influenza) (Pneumovax 23 and/or Prevnar 13)

List over-the-counter and Prescription drugs used: (include dose and frequency of use)

CURRENT

PAST

Please continue on to the next page

8. Check those triggers that cause or worsen your symptoms

Hay fever	Asthma	Eczema / Hives	Triggers (circle or check all applicable)
			House Dust (Vacuuming, Dusting, Making bed, Shaking bed, Cleaning, sweeping)
			Animals (cats, dogs, hamster, birds, guinea pig, other _____)
			Respiratory infections (Colds, sinus infections, Flu, Bronchitis)
			Exercise
			Night time
			Strong odors (newsprint, fumes), Perfumes, Air refreshers, Cleaners, Hair spray, etc.
			Emotional upset (Stress, Worry), Laughing
			Smoke (Tobacco, Auto exhaust, other _____)
			Cold air (air conditioning or outside air)
			Weather changes: Rain _____, Cold Fronts _____, Thunderstorm _____, Wind _____
			Smog (Air pollution)
			Drugs (aspirin / Ibuprofen, blood pressure medicine, glaucoma drops)
			Grass mowing, Raking leaves
			Foods / Food additives eg: Sulfites (in dried fruits, wine, beer etc) / other _____
			Menstrual cycle, Pregnancy

9. **Other allergies:** Food allergy? YES / NO Insect Sting reactions (Bee, YJ, Wasp, Hornets, Fire ants)? YES / NO
 Drug allergy? YES / NO Latex rubber allergy? YES / NO

Have you undergone allergy tests? YES / NO Skin test or Boob test, By whom? _____

Please list the results of your allergy testing? _____

Have you received allergy shots in the past? YES / NO when and how long? _____

Did the allergy shots help your symptoms? YES / NO _____

10. Home/Environmental survey (Fill in the blanks and circle those that apply)

Years at present address: _____ Age of dwelling: _____ Dwelling Type: House Apartment Trailer Dorm room Other _____

Trees around the house: Cedar Oak Maple Elm Pecan Pine Other _____ Lawn grass: Bermuda Fescue Other _____

Visible allergens inside the house: Mold-Mildew Roaches Rodents Indoor plants: Yes / No

Type of heating: Forced air Gas Radiators Baseboard Wood burning Space heaters Other _____

Type of cooling: Central Window unit fans none Humidifier use: (Central / Portable) YES / NO

Any indoor animals? (Dog, cat, hamster, bird, guinea pig, other _____) Outdoor animals? (cat, dog, horse, cattle, other _____)

Type of bed: Innerspring Foam Waterbed Air mattress Latex Gel Hybrid other Comforter: Feather / Non-feather

Type of pillow: Foam Feather Down Cotton Gel Latex Water leakage or damage in your home: Yes / No

Carpets? YES / NO Basement present? YES / NO If yes, is it Damp? Yes / No

Latex exposure in the home? Check all that apply (_____ Playtex gloves _____ Balloons _____ Condoms or diaphragm)

11. **Review of medical problems (Circle if present)** Poison ivy/oak dermatitis Chronic snoring Sleep apnea Nasal polyps
 Heart burn/Reflux Stomach ulcers Diabetes Hypothyroidism/Hyperthyroidism Hepatitis HIV AIDS Weight loss Chronic
 fever Glaucoma Hypertension Elevated cholesterol Angina Heart failure Kidney stone Chronic bronchitis/Emphysema
 Bronchiectasis Chronic abdominal pain Chronic diarrhea Colitis Autoimmune disorder Arthritis Migraine Anxiety
 Depression Anemia Osteoporosis

12. Past history of diseases and surgeries: (Circle if present) List surgeries:

Asthma Eczema/Atopic dermatitis Chronic hives Hypothyroidism/Hyperthyroidism Nasal Polyps Migraines Recurrent
 bronchitis Recurrent Pneumonia Recurrent Sinus infections Recurrent ear infections Ear tubes Sinus surgery Tonsils surgery
 Adenoids surgery Polypectomy Septoplasty

13. Family History Do any of your family members (parents, siblings, children) have the following conditions?

Nasal allergies Asthma Eczema Drug allergy Food allergy Chronic hives Hereditary Angioedema Colitis Sinus problems
 Nasal Polyps Cystic Fibrosis Emphysema Autoimmune disorder Migraine Glaucoma Anxiety / depression Immune
 deficiency Hypertension Diabetes Hypothyroidism/Hyperthyroidism

14. Social History

Marital Status: _____ Current Occupation: _____ Exposure to chemicals at work: YES / NO _____

Hobbies: _____ Smoking? YES / NO Year started smoking? _____ Number of Cigg / day _____

Quit smoking? Year _____ Does anyone smoke inside your home? YES / NO

History reviewed with the patient in detail

YES / NO

Patient Name: _____ Date of Birth: _____

Surgical History – Please check off any procedure or surgeries

Surgical Procedure	When	Explain
<input type="checkbox"/> None		
<input type="checkbox"/> Eye		
<input type="checkbox"/> Ear		
<input type="checkbox"/> Ear tubes		
<input type="checkbox"/> Thyroid		
<input type="checkbox"/> Tonsillectomy		
<input type="checkbox"/> Adenoidectomy		
<input type="checkbox"/> Appendectomy		
<input type="checkbox"/> Cholecystectomy		
<input type="checkbox"/> Hernia		
<input type="checkbox"/> Heart		
<input type="checkbox"/> Hysterectomy		
<input type="checkbox"/> Shoulder		
<input type="checkbox"/> Back		
<input type="checkbox"/> Hip		
<input type="checkbox"/> Ankle		
<input type="checkbox"/> Knee		
<input type="checkbox"/> Stomach		
<input type="checkbox"/> Breast		
<input type="checkbox"/> Removal of Ovaries Only		
<input type="checkbox"/> Tubal Ligation		
<input type="checkbox"/> C-Section		
<input type="checkbox"/> Other:		
<input type="checkbox"/> Other:		
<input type="checkbox"/> Other:		

Family History – Indicate which relative has had the following diseases:

Disease	Father	Mother	Brother	Sister	Son	Daughter	Other	No
Allergic Rhinitis								
Asthma								
Autoimmune Disorder								
Cystic Fibrosis								
Eczema/Atopic Dermatitis								
Food Allergy								
Hereditary Angioedema								
Immunodeficiency								

Photography & Publicity Release Form

I, the undersigned, do hereby consent and agree that AllerVie Health and its Subsidiaries and Partners, its employees, or agents permission **to use my name, likeness, image, voice, and/or appearance as well as my health information** as such may be embodied in any pictures, photos, video recordings, audiotapes, digital images, and the like, taken or made on behalf of these entities or their activities.

I agree that AllerVie Health and its Subsidiaries and Partners may use these in any and all media, now or hereafter known, and exclusively for any purpose consistent with their missions. These uses include, but are not limited to illustrations, exhibitions, videos, reprints, reproductions, publications, advertisements, and any promotional, marketing, or educational materials in any medium now known or later developed, including the Internet. I further consent that my name and identity may be revealed therein or by descriptive text or commentary.

I do hereby release to AllerVie Health and its Subsidiaries and Partners, its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used. I understand that there will be no financial or other remuneration due to me as a result of this agreement or anything described herein.

I also understand that AllerVie Health and its Subsidiaries and Partners are not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

I represent that I am at least 18 years of age, or the legal guardian, have read and understand the foregoing statement, and am competent to execute this agreement.

Name: _____

Address: _____

Phone Number: _____

Parent or Legal Guardian: _____

Signature

Date

NOTICE OF PRIVACY PRACTICES

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. Updated as of 8/13/2021

This Notice of Privacy Practices ("Notice") is provided in compliance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). AllerVie Health, including its affiliates, (herein referred to as the "Practice") is required by law to take reasonable steps to ensure the privacy of your medical information, as defined below.

As used in this Notice, medical information refers to your "Protected Health Information," which includes all "Individually Identifiable Health Information" transmitted or maintained by the Practice, regardless of form (oral, written or electronic). The term "Individually Identifiable Health Information" means information that:

- Is created or received by a health care provider, health plan, employer or health care clearinghouse;
- Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

WHO WILL FOLLOW THIS NOTICE. This Notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group, which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order 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 by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us 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 to follow the terms of the Notice that is currently in effect. Other ways we may use or disclose your medical information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

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 elaborate on the meaning and provide more specific examples, if you request. 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. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI. Uses and disclosures not described in this Notice will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can be paid for treating you. We may also disclose your medical information to your health insurance plan to permit it to make a determination of eligibility or coverage for insurance benefits, to review the services we provided to you for medical necessity, and to perform utilization review activities. We may also disclose medical information about you to the responsible party of your account. If you are listed as a dependent on another person's insurance policy, financial information regarding medical care provided may be mailed to that responsible party. In addition, if you do not timely pay us for the health care services we provided to you, we may also disclose limited medical information to a collection agency. We may also disclose your medical information to other health care providers, health plans or health care clearinghouses for their

payment activities. For example, we may provide your medical information to an ambulance/transportation company that provided services to you.

For 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, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, our doctors and nurses may use and disclose your medical information with each other to provide treatment to you.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

Business Associates. We may disclose your medical information to our business associates that assist us in our delivery of health care and related services, such as billing companies, lawyers, accountants and others. Before we disclose your medical information to our business associates, we will have a written contract with each of them that will require each of them to agree to maintain the privacy of your medical information.

Below are other reasons we may use and disclose your medical information without your consent or authorization:

Uses and Disclosures Required by Law. We may use or disclose your medical information as required by law, but must limit such use or disclosure to relevant information and otherwise comply with applicable legal requirements. We must also disclose your medical information to the Secretary of Health and Human Services to determine our compliance with federal privacy laws.

Public Health Activities. We may use or disclose your medical information to public health authorities authorized to receive or collect information for public health purposes, such as for preventing or controlling disease and certain regulatory activities of the Food and Drug Administration.

Abuse, Neglect, or Domestic Violence. We may use or disclose your medical information in some instances if we reasonably believe that you are a victim of abuse, neglect, or domestic violence.

Health Oversight Activities. We may use or disclose your medical information to a health oversight agency for health oversight activities authorized by law, including, for example, inspections and licensure of health care facilities.

Judicial and Administrative Proceedings: We may use or disclose your medical information under certain conditions to comply with legal proceedings, such as a subpoena or order by a court or administrative tribunal.

Law Enforcement Purposes. We may use or disclose your medical information for law enforcement purposes to law enforcement officials, such as for identification of suspects or where a crime has been committed on our premises.

Decedents. We may use or disclose medical information about decedents to coroners, medical examiners, funeral directors, and other individuals involved in your care.

Research. In limited circumstances, we may use and disclose your medical information to conduct medical research.

Serious Safety Threat. We may use or disclose your medical information where we believe it is necessary to prevent or lessen a serious threat to the safety of a person or the public.

Workers' Compensation. We may use or disclose your medical information as authorized by and to the extent necessary to comply with laws related to workers' compensation and similar programs.

To Your Personal Representatives and Family Members. We may disclose your medical information to your personal representatives that are appointed by you or authorized by applicable law. We may disclose your medical information

to a family member, friend or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. In an emergency situation and if you are incapacitated, you will be given the opportunity to agree or object when it becomes practicable.

We will not use or disclose your medical information for any other purpose unless you give us written authorization to do so. If you give us written authorization to use or disclose your medical information for a purpose that is not described in this Notice, then, in most cases, you may revoke it in writing at any time.

Your revocation will be effective for all your medical information that we maintain, unless we have taken action in reliance on your authorization.

Below are some of the circumstances when we may use and disclose your medical information only with your authorization:

Psychotherapy Notes. With limited exceptions, your authorization is required for use or disclosure of psychotherapy notes, which are notes recorded by a mental health professional documenting the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of your medical record.

Marketing. With limited exceptions, your authorization is required for use or disclosure of your medical information for marketing purposes.

Sale of Your Medical Information. Your authorization is required if we want to sell your medical information.

NOTICE OF INDIVIDUAL RIGHTS. You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice. You may ask the Practice to give you a copy of this Notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask the Practice to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

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 treatment, payment or health care 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. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

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. You must make your request in writing and you must specify how or where you wish to be contacted.

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. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Receive a Notification in the Event of Breach. You have the right to receive notification from the Practice in the event there is a breach related to your medical information.

CHANGES TO THIS NOTICE. We reserve the right to change this Notice. We will post a copy of the current Notice in the Practice’s waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact Heather Guarnera, Privacy Officer, 214-227-8112, at 4975 Preston Park Blvd, Suite 800 Plano, TX 75093. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to use will be made only with your written authorization. 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 have any questions about this Notice or would like to receive a more detailed explanation, please contact our Privacy Officer.