



New Patient Packet - Mid Atlantic

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:

- If you are coming for an allergy consultation or an allergy test, please discontinue all antihistamines FIVE days before your appointment. Common medications containing antihistamines are Benadryl, Triaminic, cough, and cold medicines. Do not stop taking Singulair or asthma inhalers. If you have questions about medications, you can find a complete list of medications to hold at allervie.com/patient-resources.
- 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.

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.

Patient Name _____ DOB _____

Patient Financial Consent Policy

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

Thank you for choosing AllerVie Health. To ensure clarity about your financial responsibilities, please review & initial each policy:

Proof of Insurance: _____ *Initials*

- Provide updated insurance information and photo ID at every visit.
- Incorrect or expired insurance information may result in patient responsibility for charges.
- Inform us of insurance changes before your appointment.
- Unverified or denied insurance coverage will be your responsibility.

Insurance Coverage: _____ *Initials*

- AllerVie Health will file claims with participating insurers as a courtesy.
- You must pay copayments, deductibles, and coinsurance at the time of service.
- Understanding your insurance benefits is your responsibility.
- You must pay charges not covered by your insurance.

Copayments, Deductibles, and Coinsurance: _____ *Initials*

- Payment of copayments, deductibles, and coinsurance is required at each visit per your insurance agreement.
- Promptly provide additional information requested by your insurer.

Referrals: _____ *Initials*

- If your insurance plan requires a referral to see an allergist or a referral authorization number, you must ensure this referral is received by our office at least 24 hours prior to your appointment, or your appointment may be rescheduled.

Self-Pay: _____ *Initials*

- Self-pay patients must make payment at the time of service.

No-Show Appointments: _____ *Initials*

- Cancel appointments at least 24 hours in advance to avoid a \$50 no-show fee.
- Appointments not canceled within this timeframe will incur a \$50 fee, which will be charged directly to your account.

Failure to Pay: _____ *Initials*

- Past-due accounts may result in suspended non-urgent care, dismissal from the practice, or referral to collections.
- Unpaid debts may be reported to credit bureaus.

Card on File: _____ *Initials*

- We encourage patients to keep a credit card securely on file to facilitate payment.
- Card information will only be used for authorized healthcare-related charges.
- Authorization remains effective until revoked in writing.

Signature and Acceptance

I understand that payment for all charges is my responsibility, regardless of insurance coverage. By signing or electronically agreeing, I legally acknowledge and accept these terms.

Patient or Legal Guardian/Responsible Party Signature Printed Name Date

Relation to Patient (if applicable): _____

Patient Name _____ DOB _____

Family Consent to Treat

CONSENT TO DISCUSS MEDICAL TREATMENT

If you would like to allow our physicians or staff to discuss your medical treatment with someone else or if you are unable to accompany your child to an appointment at one of our offices and would like to give permission for our physicians and staff to discuss your child's medical treatment with someone else in your absence, please complete the following form.

CONSENT TO DISCUSS FINANCIAL INFORMATION

As per our financial policy, unless we have written permission, we will not discuss financial information with anyone other than the person responsible for the patient's account. If there is anyone who has your permission to discuss this information with our staff, please complete the following form. Patients requiring allergy testing may have out of pocket costs depending on their insurance provider. Please know that the person who accompanies the patient is responsible for the bill or co-pay at the time of the visit.

I, _____, give permission to:

Name_____
Relationship_____
Name_____
Relationship

To discuss and provide consent for medical treatment and financial obligations for:

Patient Name: _____ Date of Birth: _____

at AllerVie Health. This permission will be valid for the duration of enrollment at AllerVie Health or until updated by patient or parent/legal guardian of minor patient.

Patient Signature_____
Date Signed

Medications to Stop 5 Days Before Allergy Testing

Over-the-Counter Antihistamines

- Loratadine (Claritin, Alavert, Allerclear)
- Cetirizine (Zyrtec)
- Levocetirizine (Xyzal)
- Fexofenadine (Allegra, Allerfex)
- Diphenhydramine (Benadryl)
- Famotidine (Pepcid, Zantac)
- Azelastine (Astepro, Astelin)
- Allergy eye drops (Pataday, Zaditor, Alaway, or drops with an "A" after the name")
- Chlorpheniramine (Chlor-trimeton)
- Doxylamine (Night-time or "PM" cold medicines like NyQuil)
- Clemastine
- Dimenhydrinate (Dramamine)
- Meclizine (Dramamine)
- Brompheniramine
- Carbinoxamine
- Tripolidine

Prescription Antihistamines:

- Anything containing any of the ingredients in the above over-the-counter antihistamines list
- Hydroxyzine (Atarax, Vistaril)
- Desloratadine (Clarinex)
- Cyproheptadine (Periactin)
- Phenergan
- Olopatadine (Patanase, Pataday, Ryaltris)

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

Prescription Nasal Sprays

- Astelin/Azelastine
- Patanase/Olopatadine

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
- Olopatadine/Azelastine Eye Drops

Medicines That You MAY CONTINUE & Should Not Interfere With Testing

- Asthma Inhalers and Nebulizers
- Montelukast (Singulair)
- Rewetting/Lubricating Eye Drops
- Saline Nasal Spray
- Steroid Nasal Spray (Flonase, Nasacort)
- Decongestant Nasal Spray (Afrin, Oxymetazoline)
- Oral Decongestants Not Containing Antihistamines (Sudafed, Pseudoephedrine)
- Cromolyn Sodium (Nasal crom, Gastrocrom)
- Zycam (Homeopathic)
- Guaifenesin (Mucinex)
- Dextromethorphan (Robitussin)

If you have any questions or are unsure if your medication contains an antihistamine, please contact our office.

Please let us know if you are antidepressants, particularly, Doxepin or Amitriptyline, as they may interfere with testing. Never stop antidepressants without consulting the prescribing physician first.

This list is not comprehensive of all medications. For any questions please contact the office prior to your visit.

PLEASE DO NOT TAKE ANTIHISTAMINES 5 DAYS PRIOR TO YOUR APPOINTMENT

Patient Name _____ DOB _____

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 #: _____

Patient Name _____ DOB _____

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: _____

Patient Name _____ DOB _____

New Patient History

Primary Care Physician: _____ Referred By: _____

Pharmacy: _____

Reason for Today's Visit: _____

Have you taken any antihistamine in the past 5 days? Yes / No If yes, when? _____

Current Medications (Dose & Frequency): _____

Medication Allergies/Sensitivities (List Reaction): _____

Food Allergies/Sensitivities (List Reaction): _____

Past Allergy & Asthma History (Circle All That Apply):

Previous Skin Tests/Blood Tests/Allergy Shots? _____

Vaccinations up to date? Yes / No Any adverse reactions to vaccinations? _____

Asthma Diagnosis? Yes / No Use of an inhaler or nebulizer? Yes / No Performed a Pulmonary Function Test? Yes / No

Stung by a bee? Yes / No Adverse reaction? Yes / No

History of Anaphylaxis? Yes / No

Important Medical History: _____

Surgical History (List Date & Procedure): _____

Emergency Room Visits in the Past Year (Date & Reason): _____

Patient Name _____ DOB _____

History of (Circle All That Apply):

Cancer	Yes / No Please specify:
Cardiac	Stroke, Heart Attack, High BP, Abnormal Rhythm, Other
Eyes	Glasses, Contact Lenses, Glaucoma, Cataracts, Other
Ears	Hearing Aids, Hearing Loss, Chronic Ear Infections, Other
Nose	Nasal Polyps, Nosebleeds, Allergic Rhinitis, Chronic Sinusitis, Other
Skin	Eczema, Hives, Other
Musculoskeletal	Arthritis, Osteoporosis, Other
Endocrine	Diabetes, Thyroid Condition, Autoimmune Disorder, Other
Gastrointestinal	Reflux, Esophagitis, Other
Respiratory	Asthma, COPD, Chronic Bronchitis, Sleep Apnea, Other
Neurological	Chronic Headaches, Other
Psych/Social	Depression, Anxiety, Other

Family History (Check All That Apply):

	Asthma	Seasonal Allergies	Food Allergies	Drug Allergies	Anaphylaxis	Eczema	Immunodeficiency
Father							
Mother							
Brother							
Sister							
Other							

Social & Environmental History (Circle All That Apply):

Occupation: _____

Martial Status: Single, Married, Divorced, Separated, Widowed, Other

Tobacco Use: Yes / No How much for how long? _____ Other Tobacco Exposure? Yes / No

Alcohol Use? Yes / No Drug Dependency? Yes / No

Heat/Cooling System: Forced Hot Air, Central Air, Window Air Conditioners, Radiators

Dehumidifier: Yes / No

Patient's Bedroom: Carpet, Hardwood, Tile, Curtains

Pets	Number	Allowed in Bedroom?	Symptoms
Cat			
Dog			
Other			

Patient Name _____ DOB _____

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****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 6/18/25.**

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

Patient Name _____ DOB _____

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, please email info@allervie.com, or send a letter to 2500 Legacy Dr., Suite 200, Frisco, TX, 75034. 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.