ALBANY INTERNAL MEDICINE

PRIVIA MEDICAL GROUP GEORGIA

WELCOME!

Thank you for choosing Albany Internal Medicine as your healthcare provider. Our patient-centered medical home practice will provide you with an expanded type of care. We will work both you and other health care providers as a team to take care of you. Albany Internal Medicine is nationally recognized by the National Committee for Quality Assurance (NCQA) as a Patient Centered Medical Home. Participation in a NCQA Recognition Program demonstrates that our physicians and other clinicians value quality health care delivery and follow the latest clinical protocols to ensure that our patients receive the best care at the right time.

We are also pleased to announce Albany Internal Medicine has partnered with Privia Medical Group Georgia, a multi-specialty group of top physicians in the state of Georgia. Albany Internal Medicine and Privia Medical Group Georgia is dedicated to providing better, more coordinated care to our patients and our decision to partner with them reflects our commitment to provide you with the highest level of care.

As part of Privia Medical Group Georgia, we are proud to offer a new patient portal that gives you convenient, 24-hour access to your personal health information. We encourage you to complete your registration and utilize the patient portal to take advantage of all the new great features. You can register by going to our web site www.albanyim.com and follow the link to our patient portal or call our office at (229) 438-3380 and ask one of our receptionists to generate a registration email invitation to our patient portal.

The patient portal allows you to:

* Access your lab results
* Request prescription refills
* Send and receive secure messages from your physician and physician's nurse.
* Receive reminders on important overdue tests
* Pay your bill and view your bill history
* Receive alerts and updates from your physician

If you are scheduled for a morning appointment, do not eat or drink after midnight except water, black coffee or diet soda. If your appointment is after 1:00 p.m., you may have a light breakfast, water, black coffee or diet soda. However, if you take medication regularly, please continue to do so on the day of your visit. If you are diabetic and take either insulin or other diabetic medications, please continue your usual routine of eating and taking your medication on the day of your visit. For all medications that you currently take, please bring all medicine bottles with you and a list of any across-the-counter medications, vitamins, or minerals that you take.

Prior to your physical appointment, please contact your insurance company to inquire if your insurance offers an annual routine/wellness benefit. It is very helpful if you can obtain a list, in writing, of any covered services or tests and frequencies allowed. Please inform your nurse and physician at the beginning of your visit that your visit is a wellness visit.

Please notify our office one business day in advance if you are unable to keep your appointment.

If you have any questions, please call our office at (229) 438-3300.

2402 Osler Court, Albany, Georgia 31707
(229) 438-3300 FAX: (229) 438-3384

AIM
ALBANY INTERNAL MEDICINE

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PATIENT INFORMATION HANDOUT

These guidelines have been established to allow quality care to all our valued patients.

1. **CLINIC OFFICE HOURS**

8:00 a.m. to 5:00 p.m.	Monday thru Friday
9:00 a.m. to 12:00 noon	Saturday (except Holidays)

2. **WALK-IN IMMUNIZATIONS & BLOOD PRESSURE CHECKS**

8:45 a.m. to 11:30 a.m.	Monday thru Friday
2:00 p.m. to 5:00 p.m.	Monday thru Thursday
2:00 p.m. to 3:30 p.m.	Friday

3. **ACUTE CARE WALK-IN CLINIC (for established patients only)**

8:00 a.m. to 9:30 a.m.	Monday thru Friday
9:00 a.m. to 11:30 a.m.	Saturday

4. **LAB TESTS - By appointment for the following times, Monday thru Friday**

8:00 a.m. to 12:50 p.m.	Monday thru Friday
2:00 p.m. to 4:30 p.m.	Monday thru Friday

5. **ROUTINE MEDICATION REFILLS**

This will be done Monday thru Friday from 8:00 a.m. to 4:30 p.m. Please do not call the office for prescription refills. Call your pharmacist to request a prescription refill to avoid delay. We highly recommend that you request prescription refills **3 business days** in advance so that you receive your prescriptions on time. If you have no refills remaining, your pharmacist will contact our office for further refills.

If you need written prescriptions, please request those **3 business days** in advance. Inform us if you need a 30 day or 90 day supply.

If your insurance company requires prior approval for your medication, please allow two weeks, as these are very complex and require us to contact your insurance company and request approval.

6. **PAIN MEDICATIONS, SLEEPING PILLS, NERVE PILLS, or OTHER CONTROLLED SUBSTANCE DRUGS**

Pain medications, sleeping pills, nerve pills, and all other Controlled Substance drugs will only be refilled 8:00 a.m. to 3:30 p.m., Monday thru Friday. **THERE WILL BE NO EXCEPTIONS.** Requests for refills must be requested **3 business days** in advance. When picking up prescription you will be required to provide your photo ID and will be asked to sign for the prescription. **If another individual is picking up the prescription the patients photo ID, photo ID of the person picking up the prescription, and a written signed note from the patient authorizing the person picking up the prescription is required. The authorized person will be asked to sign for the prescription. No exceptions to this policy are allowed.**

7. **PATIENT PORTAL**

We strongly encourage you to register and use our patient portal to request appointments, request prescription refills, request we send you laboratory test results, office visit clinical summaries, and other test results. To enroll go to the following web site link**: https://8042-1.portal.athenahealth.com** or visit our web page at www.albanyim.com. If you need help or technical support please call toll free (888) 909-3029 and a staff member will be more than happy to help you over the phone.

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Our Role as a Patient Centered Medical Home (PCMH)

Welcome and thank you for choosing our practice. We are committed to providing you with the best medical care based on your health needs. Our hope is that we can form a partnership to keep your whole self as healthy as possible.

Our patient-centered medical home practice will provide you with an expanded type of care. We will work both you and other health care providers as a team to take care of you. You will also have better access to our practice through phone and secure web access through our secure online Patient Portal. We look forward to working with you as your primary care provider in your patient-centered medical home.

As your primary care provider, we will:

- Learn about you, your family, life situation, and health goals and preferences
- Take care of any short-term illness, long-term chronic disease, and your all-around well-being
- Keep you up-to-date on all your vaccines and preventive screening tests
- Connect you with other members of your care team (specialists, Dietician, etc.) and coordinate your care with them as your health needs change
- Provide you with timely access to your physician during office hours via telephone or patient portal Monday-Friday 8am-5pm and on call physician access by calling our office via telephone after office hours
- Notify you of test results in a timely manner
- Communicate clearly with you so you understand your condition(s) and all your options
- Listen to your questions and feelings. We will respond promptly to you-and your calls-in a way you understand
- Help you make the best decisions for your care, relying upon evidence based guidelines
- Give you information about classes, community resources, or other services that can help you learn more about your condition and stay healthy
- Offer Same Day Appointments

We trust you, as our patient to:

- Know that you are a full partner with us in your care
- Come to each visit with any updates on medications, dietary supplements, or remedies you're using
- Let us know when you see other health care providers so we can help coordinate the best care for you
- Keep scheduled appointments or call to reschedule or cancel as early as possible
- Understand your health condition: ask questions about your care and tell us when you don't understand something
- Lean about your conditions(s) and what you can do to stay as healthy as possible
- Follow the plan that we agreed is best for your health
- Take your medications as prescribed
- Give us feedback to help us improve our care for you

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PATIENT INFORMATION

Name: _____ Gender: __ Male __ Female Social Security #: _____
(First, Middle Initial, Last)

Address: _____ Date of Birth: _____ Age: _____
(Street)

_____ Marital Status: __ Married __ Single __ Widowed __ Divorced
(City, State, ZIP)

Home Phone: (_____) _____-_____ Race: __ White __ Black __ Hispanic __ Other
Cell Phone: (_____) _____-_____ Ethnicity: __ Non-Hispanic or Latino __ Hispanic or Latino
Work Phone: (_____) _____-_____ __ Other or Undetermined
Email: _____ Preferred Pharmacy: _____
Preferred Method of Contact: Preferred Pharmacy Phone Number: (_____) _____-_____
__ Home Phone __ Cell Phone __ Email __Work Phone Emergency Contact: _____
__ Letter Emergency Contact Phone #: (_____) _____-_____
Referring Physician: _____ Relationship to Emergency Contact: _____

PATIENT'S EMPLOYMENT INFORMATION __ Employed __ Retired __ Student __ Other

Employer / School: _____ Employer / School Phone #: (_____) _____-_____
Employer / School Address: _____ City, State, and ZIP: _____

GUARANTOR INFORMATION __ Same as Patient Relationship to Patient: _____

Name: _____ Employer: _____
Address: _____
City, State, & ZIP: _____ Guarantor Phone #: (_____) _____-_____
Date of Birth: _____ __ Home __ Work __ Cell

PRIMARY INSURANCE INFORMATION

__ Health __ Liability __ Other _____
Insured Party: _____
Insured Phone #: (_____) _____-_____
Relationship to Patient: _____
Insured's SS #: _____
Insured's Date of Birth: _____
Insured's Employer: _____
Insurance Company: _____
Insured's ID #: _____
Policy Group #: _____

SECONDARY INSURANCE INFORMATION

__ Health __ Liability __ Other _____
Insured Party: _____
Insured Phone #: (_____) _____-_____
Relationship to Patient: _____
Insured's SS #: _____
Insured's Date of Birth: _____
Insured's Employer: _____
Insurance Company: _____
Insured's ID #: _____
Policy Group #: _____

I authorize Albany Internal Medicine and Privia Medical Group Georgia to perform treatment deemed by the physician in exercise of professional judgment to be of appropriate kind and method on me or my dependent. I hereby authorize Albany Internal Medicine and Privia Medical Group Georgia to release any information acquired in my examination or treatment to any insurer, government agency providing benefits, or to anyone for billed charges.

SIGNED: _____ DATE: _____

I hereby assign to and authorize payment to Albany Internal Medicine and Privia Medical Group Georgia all benefits payable under the terms of any insurance policy listed above. I realize the insurance, workers compensation, and or liability claims may not pay the entire bill. I agree to pay the difference or the entire bill if necessary. I agree to allow Albany Internal Medicine and Privia Medical Group Georgia, or its agent, to call me directly to my home phone, cell phone, or employment phone number. I also agree to pay costs of collection, including attorney's fees and waive my exemption under the laws of the State of Georgia.

SIGNED: _____ DATE: _____

PATIENT CONSENT AND AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

By signing below, you hereby consent and authorize Albany Internal Medicine and Privia Medical Group Georgia to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose of treatment, payment and health care operations. You may refuse to sign this consent form but by doing so we may not be able to treat you.

You should read the Notice of Privacy Practices for protected health information made available to you by us before signing this Consent. The terms of the Notice of Privacy Practices may change from time to time, and you may obtain a revised copy of it by asking s for a copy.

Your "protected health information" means all health information and medical records, including your demographic information, collected from you and created or received by your physician, another health care provider, a health plan, your employer or a health care claims clearinghouse. Additionally, I understand this authorization includes release of all medical records, which may include information regarding Human Immunodeficiency Virus (HIV), psychiatric and/or drug/alcohol abuse, Venereal disease, and or any other statutory protected disease. I understand that I may revoke this authorization and consent in writing at any time except to the extent that Albany Internal Medicine has acted in reliance upon this authorization. This protected health information relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information identify you.

If someone calls or visits and asks about you, can we acknowledge that you are here?
Yes _____ No_____

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

- □ Home Telephone: _____
  - □ OK to leave message with detailed information
  - □ Leave message with call-back number only
- □ Work Telephone: _____
  - □ OK to leave message with detailed information
  - □ Leave message with call-back number only
- □ Written Telephone: _____
  - □ OK to mail to my home address
  - □ OK to mail to my work/office address

I hereby give permission to the person(s) listed below to authorize treatment, attend examinations, and to receive information about the care of the below named patient. This includes but is not limited to: information about the patient's general medical condition and diagnosis (including treatment and payment options), access to medical records (protected health information), prescription pick-up, and the ability to set appointments.

1: _____ Relationship to you: _____

2: _____ Relationship to you: _____

3: _____ Relationship to you: _____

_____ _____ _____
Patient Signature Date Medical Record Number

_____
Albany Internal Medicine Witness Signature

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(229) 438-3300 FAX: (229) 438-3384

Financial Policy

Welcome to Albany Internal Medicine and Privia Medical Group! We are pleased that you have chosen us as your care provider. Our mission is to provide you with the highest level of professional medical care with the highest degree of patient satisfaction. One important aspect of optimal patient care is to have an agreement as to financial responsibility to avoid any misunderstandings and to ensure timely payment for services.

Albany Internal Medicine and Privia Medical Group policy requires that all patients sign the Authorization and Consent for Treatment Form prior to receiving medical services. The form confirms that patients understand services being provided are necessary and appropriate. The form also advises patients of their complete financial responsibility for all medical services received without regard to insurance eligibility or coverage determinations.

Payment Responsibility

Patients or their legal representative are ultimately responsible for all charges for services rendered. Payment is expected at time of service for all charges owed for the current visit as well as any prior balance. For those insurance plans with real time adjudication, payment will be collected at check out for charges incurred that day. For insurance plans that do not provide immediate patient responsible information, settlement of your balance can be accomplished via card-on-file (preferred) or you may pay a deposit on date of service.

For card-on-file, we will charge your card for the balance you owe as soon as your insurance company informs us of the patient responsibility. Under the deposit option, you may pay an estimate of the expected patient responsibility and we will settle the balance upon receipt of the Explanation of Benefits (EOB) from your insurance company by either sending a refund in case of overpayment or send a statement for the balance due. Both payment options benefit you by reducing administrative burden and settling your portion of the bill in a timely manner.

For Annual Wellness visits or Physical Exams for which you require additional services beyond the scope of the wellness exam or physical, an additional charge will be incurred and you will be asked to pay resulting additional copayments or patient responsibility amounts.

TYPES OF PAYMENTS

1. Co-payments. We are contractually required by insurance carriers to collect co-payments at the time of services are rendered. The patient's appointment may be rescheduled if he/she is not prepared to make this payment.
2. Deductibles. Some insurance plans require patients to pay a predetermined amount before services will be covered.
3. Co-insurance. Some insurance plans require that patients pay a predetermined percentage (e.g. 20%) of the allowed charge amount.
    - If amount can be determined at time of service, amount will be collected.
4. Uninsured Patients (Self-Pay). Payment for all services rendered is due at the time of service. Patients paying the total of charges for that days visit will be given a prompt pay discount. If the total charge amount is not available at the time of checkout, the patient will be required to pay a deposit that will be applied to his/her charges. If the deposit exceeds actual charges then a refund will be issued.
    - New patients: total charge or a minimum $250 deposit.

- Established patients: total charge or a minimum $150 deposit.
- Uninsured patients having a procedure will be required to pay the total charge amount of the anticipated charges or a minimum $250 payment to the provider's office prior to the procedure being performed.

5. Out-of-Network. Patients being seen as Out of Network will be required to pay a payment for that days visit at the time services are rendered. We will courtesy bill your insurance company. If the total charge amount is not available at check out, the patient will be required to pay a deposit that will be applied to his/her charges as described in the Payment Responsibility section above.

- New patients: the total charge amount or a minimum $250 deposit.
- Established patients: total charge or minimum $150 deposit.

6. Non-Covered. "Non-covered" means that a service will not be paid under a patient's insurance contract. If a patient is unsure whether a service is covered by his/her plan, it is ultimately the patient's responsibility to call his/her insurance carrier to determine what the schedule of benefits allows. If non-covered services are provided, the patient will be expected to pay for the services at the time of service. Appeal procedures are generally available and billing staff will assist patients in attempting to resolve adverse determinations. Under no circumstances will billing staff falsify or change a diagnosis or symptom in order to convince an insurer to pay for care that is not covered.

For Medicare, all non-covered services will be communicated to the patient prior to treatment and documentation of his/her acceptance of financial responsibility will be obtained prior to providing service. The Centers of Medicare and Medicaid Services (CMS) has mandated the form "Advance Beneficiary Notice (ABN)" to be used for this notification.

Insurance

All patients must present their insurance card (if applicable) and proof of identification (e.g. Photo ID, Driver's license) at every visit. Patients who do not provide current proof of insurance may be billed as a self-pay patient. If at a later time the patient presents his/her insurance card(s), services already rendered may or may not be retroactively billed depending on the insurance's claim filing requirements.

The patient's insurance is a contract between him/her (and/or employer) and the insurance carrier. Albany Internal Medicine and Privia Medical Group are not a part of this contract. For this reason, we cannot waive copays or deductibles.

Patients are responsible to:

- Know if a referral is necessary for office visits. (If patient chooses to NOT follow payer policy regarding obtaining a referral from Primary Care Provider, patient can be seen as a Self-Pay and payment in full at time of service will be required.)
- Check with their insurance carrier to determine if prescribed testing is covered under their medical coverage policy. (If patient chooses to have non-covered testing, payment in full at time of service will be required.)
- Contact the insurance carrier to determine the schedule of benefits and if a co-payment or deductible applies.
- Arrive for appointments with proper documentation.
- Appeal adverse determinations.

Insurance Verification. Verification of patient's insurance eligibility will be done either electronically through the practice management system or manually, 2 business days prior to scheduled visits. If staff members are unable to confirm active insurance coverage for a patient, the patient will be contacted

and advised of his/her insurance eligibility status. Patients who are unable to present an alternative form of active insurance coverage prior to the visit will be informed that they classify as self-pay and will be required to pay at the time services are rendered or may reschedule their appointment. For same day appointments, eligibility will be checked as the appointment is made.

Insurance Claims Processing. Albany Internal Medicine and Privia Medical Group accepts assignment of benefits for many third party carriers. In accordance with the insurance carrier contracts patients will be required to pay co-payments at the time services are rendered. Albany Internal Medicine and Privia Medical Group will submit charges for services rendered to the insurance carrier. The patient or guarantor will be expected to pay the entire amount that is determined to be patient responsibility. These fees are for physician services only and there may be additional bills from laboratory, radiology, or other diagnostic related providers.

Non-contracted Insurance. If non-contracted "out of network" insurance (an insurance company with which our providers are not contracted) has not paid within thirty (30) days, the remaining balance, beyond the amount we collect at time of service, is the patient's responsibility.

Outstanding Balances

Any outstanding balance that is due from the patient is payable in full upon receipt of statement. In the event a patient presents for an office visit and has an outstanding balance, a request for payment will be made.

Statements are generated on a twenty-eight (28) day cycle. Patients who fail to respond to statements will be placed into collection status. Patients with an outstanding balance for more than (90) days may be referred to an outside collection agency and will be charged a $20 collection fee in addition to the balance owed.

A patient with unpaid delinquent accounts or accounts which have been written off to bad debt may not receive additional scheduled services unless special arrangements have been made. The patient may be discharged from the practice, however, in all situations the urgency of treatment will be taken in consideration.

Late Arrivals, Cancellations, and No-shows

Late arrivals. Patients who arrive late for a scheduled appointment may be asked to reschedule the appointment or wait for an open appointment time on that day's schedule. The physician may decide to work the patient in but this is at the discretion of the physician. There is no option or preference given for a particular provider.

Cancelations. Patients shall call at least one (1) business day in advance if unable to keep a scheduled appointment time or the practice will consider the patient a "no-show".

In accordance with our practice guidelines, a patient may be discharged from the medical practice following three (3) no-shows in a one-year period (365 days).

No-shows will be documented in the practice management system and a history of no-shows may result in refusal to schedule future appointments. Albany Internal Medicine and Privia Medical Group staff will notify a patient via regular mail when this decision is made. Patients may still have access to Albany Internal Medicine and Privia Medical Group providers who accept walk-in appointments. First visit

appointments that are repeatedly cancelled and new patient no-shows will count toward the patient's no-show record and may result in non-acceptance or discharge.

New Card-on-File Feature

As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is scanned and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes the checkout process easier, faster, and more efficient.

We have implemented a similar policy at our practice. You will be asked for a credit card at the time you check-in, we will scan the card in our system, and the information will be held securely until your insurance has paid their portion and notified us any additional amount owed by you. At that time, you will receive a notification that the remaining balance owed will be charged to your credit card, and you will receive a receipt for the charge.

This will be an advantage to you, since you will no longer have to receive statements, write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out, and reduce the difficulty in following up with patients, allowing us to focus on more important issues, like your care. The combination will benefit everybody in helping to keep the cost of health care administration down.

This new program will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, do not hesitate to ask.

Thanks for helping us run a better practice!

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AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ authorize _____
Patient Name Hospital / Medical Group / Physician Name

release my Medical Records to _____.

Please release the following information for Date of Service: _____.

_____ Discharge Summary	_____ Consult Report	_____ ER Reports
_____ History & Physical	_____ Lab Report	_____ Eye Exam Report
_____ Operative Report	_____ Radiology Report	_____ Mammography Report

_____ Other Reports: _____

Social Security Number: _____ Date of Birth: _____

_____ Please FAX the records to: _____

_____ Please Mail the requested medical records to the address at the bottom of this page.

I understand this authorization includes release of medical records, which may include information regarding Human Immunodeficiency Virus (HIV), psychiatric and/or drug/alcohol abuse, Venereal disease, and or any other statutory protected disease. This authorization and consent will expire 90 days following the date signed. I understand that I may revoke this authorization and consent in writing at any time except to the extent that action has been taken in reliance thereon. If I sign for my minor child, I consent that I am the custodial guardian. Furthermore, I understand that these records are for the purpose of continuity of care and cannot be further released or disclosed.

_____ Date: _____
Patient/Guardian Signature

_____
Relationship to Patient

_____ Date: _____
AIM - Witness Signature

2402 Osler Court, Albany, Georgia 31707
(229) 438-3300 FAX: (229) 438-3384

NOTICE OF PRIVACY PRACTICES

Albany Internal Medicine (AIM) / Privia Medical Group Georgia

Effective Date September 1, 2013 (Updated June 7, 2016)

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

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer:	Bruce A. Trickel, CMPE
Mailing Address:	Albany Internal Medicine, 2402 Osler Ct, Albany, GA 31707
Telephone:	(229) 438-3300
Fax:	(229) 438-3384
Email:	btrickel@albanyim.com

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the

purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

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

- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide

you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare

operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health 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. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website (www.albanyim.com).

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.