PATIENT DEMOGRAPHIC INFORMATION:

Last Name:_____ Date of Birth:_____

First Name:_____ Sex: ◯ Male ◯ Female

Social Security Number:_____

Marital Status: ◯ Married ◯ Single ◯ Divorced/Separated ◯ Domestic Partner

Cell phone:_____ Home phone:_____

Email:_____

Address:_____

City:_____ State:_____ Zip Code:_____

PATIENT INSURANCE INFORMATION:

Primary Insurance Company:_____

Plan Name:_____ Phone Number:_____

Name of Insured:_____ Relationship:_____

Member ID #:_____ Group #:_____

Secondary Insurance Company:_____

Plan Name:_____ Phone Number:_____

Name of Insured:_____ Relationship:_____

Member ID #:_____ Group #:_____

Guarantor Information (if different from patient):

Name:_____ Social Security Number:_____

Date of Birth:_____ Cell Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Email:_____

PHARMACY INFORMATION:

Retail Pharmacy:_____

Pharmacy phone number:_____

Pharmacy address:_____

Mail Order Pharmacy:_____

Pharmacy phone number:_____

Pharmacy address:_____

Do you consent to the retrieval of your prescription filling history? ◯ Yes ◯ No

Primary Medical Doctor:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Emergency Contact Information:

Name:_____ Phone:_____

Health Care Proxy (If different from Emergency Contact):

Name:_____ Phone:_____

PATIENT GENERAL MEDICAL HISTORY:

Reason for visit:

Have you ever suffered from or been diagnosed from the following conditions?

- ☐ Stroke
- ☐ Seizure
- ☐ Migraines
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Congestive Heart Failure
- ☐ Cardiac Arrythmias
- ☐ Coronary Disease
- ☐ Other heart disease (Please specify)
- ☐ Asthma
- ☐ COPD
- ☐ Cancer (Specify type)
- ☐ Pancreatitis
- ☐ Gallstones
- ☐ Celiac disease
- ☐ Kidney Disease (Specify type)
- ☐ Broken Bones or Fractures
- ☐ Arthritis
- ☐ Other

Please list dates and types of any surgeries:

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____

PATIENT ENDOCRINE HISTORY:

Have you ever been diagnosed with:

- ☐ Pituitary disorders or tumors
- ☐ Thyroid disorders
- ☐ Thyroid nodules
- ☐ Diabetes (specify type)
- ☐ Adrenal Insufficiency
- ☐ Cushing's syndrome
- ☐ Other adrenal disorder (specify type)
- ☐ Osteoporosis
- ☐ Parathyroid disorder
- ☐ Infertility
- ☐ Irregular Menses
- ☐ Erectile Dysfunction

Have any members of your family been diagnosed with:

- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Autoimmune Disorder (specify)
- ☐ Other endocrine disorder (specify)

PATIENT SOCIAL HISTORY:

Do you currently or have you ever smoked cigarettes? ◯ NO ◯ YES ◯ QUIT (DATE)

How often do you drink alcoholic beverages?

Do you use any recreational or street drugs (eg marjiuana)?

PATIENT MEDICATION HISTORY:

Please list all prescription medications and supplements/vitamins you currently use:
Include the dose and frequency

Do you have any allergies to food, medications, or other substances? ◯ No known allergies ◯ Yes, see list

If yes, please list:

Sarah Fishman, MD/PhD
Endocrinologist

212.729.8663
sarah.fishman@premierendocrine.com

TELEMEDICINE INFORMED CONSENT

Telemedicine allows patients to access medical care using audio-video interface such as videoconferencing.

Telemedicine services may be offered as sole or partial treatment. Telemedicine services involve the use of audio, live video (like Skype, Zoom, Etc.,), or other electronic communications to interact with you for the purpose of providing medical care, and/or follow-up services on an individual basis. A potential risk of telemedicine is that your specific concerns, or unforeseen technical issues, may still necessitate a face-to-face session as part of your ongoing treatment.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional and unintentional corruption.

Additionally, in RARE circumstances security protocols could fail causing a breach of patient privacy. All laws concerning patient access to medical records and copies of medical records apply to telemedicine. You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consultation without affecting your right to future care or treatment. The alternative to telemedicine is a face-to-face visit with a clinician.

By signing this form, I understand the following:

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. However, I understand I may have to travel further to obtain care.
- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.
- I understand that it is my duty to inform my provider of any other healthcare providers involved in my medical/ psychiatric care.

I have read and understand the information provided about regarding telemedicine, have discussed it with my healthcare providers or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Sarah Fishman MD, PhD. to use telemedicine in the course of my diagnosis and treatment.

_____ ____/____/____
Patient's Name (Print) Date of Birth (mm/dd/yyyy)

_____ ____/____/____
Signature of Patient/Responsible Party (Representative Status) Date (mm/dd/yyyy)

If the above person is the legal representative of the patient, please write the patient name directly above, and indicate your name and legal representative status giving you the authority to sign on behalf of the patient.

Sarah Fishman, MD/PhD
Endocrinologist

212.729.8663
sarah.fishman@premierendocrine.com

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND OFFICE POLICIES

By signing below, I attest that I have received notice of the Privacy Policies and Office Practices of Sarah Fishman MD, PhD PC on the date indicated. I understand any questions I have regarding these privacy and office policies may be directed to the patient privacy officer indicated in this notice.

CONSENT TO USE OF EMAIL COMMUNICATION

I hereby consent to communication with Dr. Sarah Fishman and any members of her staff via email, text message, SMS, and other electronic communication regarding my medical care including but not limited to test results, treatment options, appointments, imaging studies and medications. I understand that e-mail and other electronic communication is not a confidential means of communication and that e-mails and electronic communication initiated by me intended for Dr. Sarah Fishman and/or her staff or initiated by Dr. Sarah Fishman and/or her staff intended for me may be intercepted or unintentionally transmitted to third parties. Any email or other electronic communication between myself and Dr. Sarah Fishman and/or her staff may be printed and added to my medical record. I acknowledge that any electronic communication via email or text is not a substitute for direct medical care and that in the event of an urgent or emergency situation, I should attempt to contact a medical provider by phone or go to an emergency room and not rely on email or other electronic communication.

_____ ____/____/____

Patient's Name (Print) Date of Birth (mm/dd/yyyy)

_____ ____/____/____

Signature of Patient/Responsible Party (Representative Status) Date (mm/dd/yyyy)

If the above person is the legal representative of the patient, please write the patient name directly above, and indicate your name and legal representative status giving you the authority to sign on behalf of the patient.

Sarah Fishman, MD/PhD
Endocrinologist

212.729.8663
sarah.fishman@premierendocrine.com

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Your signature below forms a binding agreement between, on the one hand, SARAH FISHMAN, M.D. PhD PC (the "Practice") and, on the other hand, the undersigned Patient who is receiving medical services or the undersigned Responsible Party for patients under 18 years old or holding other legal representative status. The Responsible Party is the individual who is financially responsible for payment of medical bills. This includes all fees for medical visits, procedures, and tele-health communications.

Payment Due in Full at the Time of Service:
All charges for services rendered are due and payable in full at the time of service, regardless of whether you have insurance. You hereby waive any and all claims against Practice with respect to the processing of insurance claims and the payment of benefits from the insurance company to you. **We are out of network with ALL insurance plans except traditional government issued Medicare. We do not participate in managed medicare or medicaid plans.** A typical initial medical visit fee is $650 and typical follow up visit fee is $295. Blood samples are sent to an outside laboratory who may bill your insurance for additional fees. Acceptable payment methods include cash, credit card or check.

Returned Check Policy:
If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the Patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 check service charge. Once notice is received of the returned check, Practice will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 check service charge.

Missed Appointments and Late Cancellations:
You may be charged a fee of $75.00 if you miss an appointment or fail to cancel an appointment at least 24 hours prior to your scheduled visit. If you fail to appear for your appointment within 20 minutes after the scheduled time, the appointment will be considered missed without appropriate cancellation and you will be subject to a fee of $75.00. You must pay this balance in full in order to continue to receive medical care.

Form and Record Requests:

You may request copies of your records at anytime. A collection fee of $20.00 and printing fee of $0.20 per page may be charged. Pay is expected on delivery of records. You may be responsible for additional postage fees. If requesting electronic copies, a collection fee may be assessed. Electronic records requested via fax will incur a fee of $0.20 per page. Forms other than prior authorization requests will incur a $25.00 fee due prior to release of requested forms.

Non-Payment on Account:
Should collection proceedings or other legal action become necessary to collect an overdue account and missed appointments/ late cancellations, the Patient or the Patient's Responsible Party understands that Practice has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The Patient, or the Patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at a 18% per annum (or the highest rate permitted by law, if lesser), all court costs and attorneys' fees, and collection fees, which will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services, or as the Responsible Party. Your signature verifies that you have read this Patient Financial Responsibility statement, understand your responsibilities, and agree to these terms. A photocopy of this document shall be as effective and valid as the original.

_____ ____/____/____
Patient's Name (Print) Date of Birth (mm/dd/yyyy)

_____ ____/____/____
Signature of Patient/Responsible Party (Representative Status) Date (mm/dd/yyyy)

If the above person is the legal representative of the patient, please write the patient name directly above, and indicate your name and legal representative status giving you the authority to sign on behalf of the patient.

Sarah Fishman, MD/PhD
Endocrinologist

212.729.8663
sarah.fishman@premierendocrine.com

ONLINE APPOINTMENT REQUESTS

We are pleased to offer our patients the opportunity to book appointments through our website, ZocDoc, and other online venues. In order to protect our practice and staff from the cost of "no-shows" and last minute cancellations, a valid credit card number is requested to complete your booking. Your card will not be charged unless you fail to arrive for your appointment or cancel your appointment within 24 hours of your appointment time. Please complete the attached credit card authorization or call our office to provide your credit card information.

_____ _____/_____ _____
Credit Card Number: Expiration: CVV:

_____
Name of credit card holder (if different from patient):

_____
Billing Address (if different from patient)

_____ ____/____/____
Patient's Name (Print) Date of Birth (mm/dd/yyyy)

_____ ____/____/____
Signature of Patient/Responsible Party Date (mm/dd/yyyy)

NOTICE OF OFFICE POLICIES AND PRACTICES
SARAH FISHMAN, M.D., PhD, P.C.

Effective Date: January 1, 2021

WE BELIEVE IN TEAMWORK

We will make every effort to ensure that your experience exceeds your expectations. We are committed to providing you with beneficial and appropriate medical care. You will have the opportunity to have all your questions and concerns addressed about your condition, including treatment options and cost. Every member of this medical team will strive to treat you with respect and dignity and without regard to age, race, religion, disability or national origin. You have the right to be treated without discrimination. You can expect privacy and confidentiality with respect to your medical care.

We will also:

- Return phone calls and emails promptly
- Provide medication refills for up to 180 days*
- Minimize your risk of exposure to COVID or other infectious agents
- Provide you with test results upon request
- Update your primary physician or other consultant physicians regarding changes in your health care plan

It is important that you take an active role in your healthcare. We would like you to participate in choosing the best treatment options for your condition. You have the right to consent or refuse any treatment offered.

You agree to:

- Inform us of any issues with filling prescriptions or adhering to prescribed treatments
- Follow up at regular intervals as agreed upon in order to keep receiving prescription refills*
- Keep your appointments and arrive on time. Please inform us at least 24 hours in advance if you are unable to keep an appointment**
- Provide accurate and truthful information about your medical history, including but not limited to current and former medication use, substance use or abuse, current or former mental health conditions.
- Pay your bills promptly, and provide all relevant demographic and insurance information for collection of fees from third party entities.

THANK YOU FOR THE OPPORTUNITY TO PARTICIPATE IN YOUR CARE

*Patients must have an appointment either in-person or virtual every six months in order to continue receiving refills. In some cases, a maximum of 90 days may be offered if deemed appropriate by the medical staff. Prescription refills may be denied if you have not been seen in the past six months or if you have an outstanding balance on your account for more than 90 days.

**There is a $75 no-show fee for all missed appointments or for those not cancelled within 24 hours. Arrival at the office more than 20 minutes after your appointment time may be considered a missed appointment and we cannot guarantee you will be seen. We require a credit card be kept on file to hold all appointments. Your card will not be charged if you arrive for your appointment.

NOTICE OF PRIVACY PRACTICES
SARAH FISHMAN, M.D., PhD, P.C.

Effective Date: JULY 1, 2018

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

If you have any questions about this notice, please contact our Privacy Officer (his/her contact information is set forth at the very end of this notice).

Terms used, but not defined, in this notice have the meanings set forth in the Federal HIPAA Law.

WHO WILL FOLLOW THIS NOTICE

In accordance with the HIPAA law, this notice describes SARAH FISHMAN, M.D., PhD, P.C.'s privacy practices and that of:

- Any health care professional authorized to enter information into your practice chart and review your charts, testing and other results on its behalf.
- All employees, staff and other practice personnel (and contracted administrative service providers).

All of these follow the terms of this notice. In addition, they may share medical information with each other for treatment, payment or health care operations, and any other purposes described in this notice and/or allowed by applicable law.

OUR PRIVACY OBLIGATIONS REGARDING MEDICAL INFORMATION

The practice understands that medical information about you and your health is personal, and the practice is committed to protecting medical information about you and keeping it private. The practice creates a record regarding your information as well as information regarding your diagnosis, treatment and services you receive from the practice. The practice needs this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the medical information/"protected health information" or "**PHI**" which the practice creates or receives, whether made by practice personnel or received from another health care provider. Medical information includes information that can be used to identify you that is created or received about your past, present, or future health or condition, the provision of healthcare to you, or the payment for the health care. We are required by law to protect the privacy of this information. Be aware, however, that your other health care providers may have different policies or notices regarding their use and sharing of your medical information that they create or maintain.

This notice will tell you about the ways in which the practice may use and share your medical information. This notice also describes your rights and certain obligations the practice has regarding the use and sharing of medical information.

The practice is required by law to:

- Make sure that information that identifies you is kept private (with certain exceptions) and secure;
- Follow the duties and privacy practices described in this notice and give you a copy of it; and
- If medical information is used or disclosed in violation of the law, notify you promptly if the use/disclosure is a "**Breach of Unsecured Protected Health Information**" (as such terms are defined by the Federal HIPAA Law), and also notify you pursuant to any State law that may be applicable.

HOW WE MAY USE AND SHARE YOUR MEDICAL INFORMATION

The following categories describe different ways that we are permitted to use and disclose/share your medical information. For the most typical uses and disclosures we make, we will explain what we mean and try to give some examples. Not every specific use or disclosure or type of use/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. In many of the instances briefly described below, we will additionally have to meet conditions before we can use or share your information for the purposes described. Any other uses and disclosures not described in this notice or otherwise not permitted by law without an authorization will not be made without your authorization.

HIGHLY SENSITIVE INFORMATION: SPECIAL AUTHORIZATION MAY BE REQUIRED

In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described in this notice.

Our records received from third party providers or prepared by us may contain information regarding your mental health, substance abuse, sexually transmitted diseases, psychotherapy, HIV/AIDS or other types of highly sensitive/protected information. Information of these types are typically protected by additional restrictions under state law, which we will comply with as applicable.

Government health benefit programs, such as state Medicaid programs, may also limit the sharing of beneficiary information for purposes unrelated to the program.

DISCLOSURES THAT GENERALLY REQUIRE HIPAA AUTHORIZATION (MARKETING AND SALE)

Under the HIPAA law, there are some circumstances where we can only use and share medical information if you have signed a HIPAA authorization/given us written permission.

For example, your authorization is required for most uses and sharing of your medical information for "Marketing" purposes, including subsidized treatment communications, or for disclosures that constitute the "Sale" of medical information. Please be aware, however, that HIPAA's definitions of "Marketing" and "Sales", and the restrictions related thereto, are technical, include exceptions, and do not apply to all situations that you may personally consider to be marketing or sales. We are permitted to use and/or share medical information for marketing or sales purposes in accordance with HIPAA and State law, which in some, but not all, situations requires your authorization or consent to do so. If your authorization is not required, and HIPAA/State law allows for a use that you may personally consider to be a use or sharing for marketing/sales purposes, we may utilize your information for such purposes without your consent (examples include, but are not limited to, face-to-face communications to you about a product or service, to provide reminders, research purposes, and the sale, transfer, merger or consolidation of all or part of the practice).

SHARING AT YOUR REQUEST

We may disclose/share information when requested by you. This disclosure at your request may require a written authorization by you. Any authorizations that you give can be revoked at any time.

FOR TREATMENT

We may use and share medical information about you to provide you with medical treatment, healthcare, or other related services (including for care coordination purposes). The practice may share medical information about you to doctors, nurses, assistants, technicians, health care students, or other personnel who are involved in diagnosing or treating you. The practice also may share medical information about you with people outside of the practice who may be involved in your medical care, such as family members, facilities, and physicians or other practitioners. For example, an outside doctor

treating you for an injury asks a practice practitioner about a particular test result, or we internally share medical information about you in order to coordinate the different things you need from us.

Additionally, we may share your medical information with physicians and other health care providers as a member of an Accountable Care Organization ("**ACO**"), Regional Health Information Organization ("**RHIO**") or other Health Information Exchange ("**HIE**"). In some (but not all) cases, there may be an "opt out" right or other rights particular to an ACO, RHIO or HIE – please contact our Privacy Officer utilizing the information below (contact information is set forth at the very end of this notice) if you would like more information on "opt out" or other rights you may have, to the extent that we then-participate in these organizations.

FOR PAYMENT

We may use and share medical information about you so that the diagnosis, treatment and services you receive at or from the practice may be billed to and payment may be collected from you, an insurance company, or a third party. The practice may also share your medical information with another health care provider or payor of health care for the payment activities of that entity. For example, we may need to give your health plan information about a test or diagnosis you received from us so your health plan will pay us or reimburse you for the test. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, referrals, or to determine whether your plan will cover the treatment. We may also provide basic information about you and your health plan, insurance company or other source of payment to practitioners outside the practice who are involved in your care, to assist them in obtaining payment for services they provide to you. The practice may also need to use and share your medical information in various appeals processes to defend the necessity of services offered in the past, and to pursue collections actions for services which we have rendered to you.

If you do not want us to share medical information about you with your health plan, you have the right to pay for all services and care out of pocket in full, and to inform us that you wish to restrict the information shared with your health plan. For more information on this limited restriction, see your rights listed below.

FOR HEALTH CARE OPERATIONS

The practice may use and share your medical information for health care operations. These uses and disclosures are necessary to run the practice and make sure that all of our patients receive competent, quality health care, and to maintain and improve the quality of health care that the practice provides. The practice may additionally provide your medical information to various governmental or accreditation entities to maintain any license(s) and/or accreditations we may have. For example, the practice may use medical information to review our treatment and services and to evaluate the performance of our staff. The practice may also combine medical information about many practice patients to decide what additional services the practice should offer, what services are not needed, and whether certain new treatments are effective.

INCIDENTAL USES AND DISCLOSURES

We may occasionally inadvertently use or share your medical information when such use or disclosure is incident to another use or disclosure that is permitted or required by law. Please be assured, however, that as much as possible, the practice has appropriate safeguards in place in an effort to avoid such situations or to otherwise limit the extent of the disclosure.

LIMITED DATA SETS

We are permitted to use or share certain parts of your medical information, called a "limited data set," for purposes of research, public health reasons or for our health care operations, subject to certain conditions.

DE-IDENTIFIED INFORMATION

The practice may use or share your medical information to create information that does not identify you in accordance with HIPAA. Once the practice has de-identified your information, it can be used or shared in any way according to law.

CERTAIN DISCLOSURES BY MEMBERS OF WORKFORCE

In certain circumstances, members of the practice's workforce are permitted or even required to share your medical information with a health oversight agency, public health authority, law enforcement official, or health care accreditation organization or attorney hired by the workforce member.

SHARING WITHIN ORGANIZED HEALTH CARE ARRANGEMENT

We may share medical information with covered entities participating in any organized health care arrangement in which we participate, as necessary to carry out treatment, payment, or health care operations relating to the organized health care arrangement.

HEALTH-RELATED PRODUCTS AND SERVICES

So long as done in compliance with the HIPAA marketing/sale of PHI rules, we may use and share medical information to tell you about health-related products or services that may be of interest to you. If you do not wish us to contact you regarding health related-products and services, you must notify us in writing and state that you wish to be excluded from this activity.

TO INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE (AND YOUR OPPORTUNITY TO OBJECT)

We may release medical information about you to a friend or family member who is involved in your medical care, unless you object in whole or in part. We may also give information to someone who helps pay for your care. Unless there is a specific written request/objection from you to the contrary, we are also permitted under the HIPAA rules to tell your family or friends your condition and that you are being cared for by the practice in limited circumstances.

In addition, to the extent applicable, the practice may share certain medical information about you with an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you are unconscious or otherwise unable to communicate and a third party provider so requests, we may go ahead and share your information if we believe it is in your best interests.

FOR RESEARCH

Under certain circumstances, we are permitted to use and share medical information about you for research purposes. In some situations, your authorization is required in connection with research uses and disclosures.

TO COMPLY WITH THE LAW

We will share medical information about you when required to do so by federal, state or local law, including with the U.S. Department of Health if it wants to see that we're complying with federal privacy law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY

We may in certain circumstances, and only if allowed by State law, use and share medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

THIRD PARTIES/BUSINESS ASSOCIATES

We may share your medical information to third parties (sometimes called Business Associates) with whom the practice has contact to perform services on the practice's behalf. If we share your information with these entities, we will have a written agreement with them to safeguard your information.

WORKERS' COMPENSATION; LAW ENFORCEMENT; OTHER GOVERNMENT REQUESTS

We may use or share medical information about you in certain circumstances for: (i) workers' compensation or similar programs; (ii) law enforcement purposes or with law enforcement officials in certain circumstances; and (iii) special government functions such as military, national security, intelligence and protective services.

PUBLIC HEALTH AND SAFETY ISSUES

We may share medical information about you for certain public health and safety purposes, including, without limitation, the following: (i) preventing/controlling disease, injury or disability; (ii) reporting births and deaths; (iii) to report regarding the abuse or neglect of children, elders, and dependent adults; (iv) to report reactions to medications or problems with products; (v) to notify you regarding product recalls; (vi) to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; (vii) to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence; and (viii) to notify emergency response personnel regarding possible exposure to HIV/AIDS, to the extent necessary to comply with State and federal laws.

HEALTH OVERSIGHT ACTIVITIES

We may share medical information with a health oversight agency for activities authorized by law.

LAWSUITS AND ADMINISTRATIVE PROCEEDINGS

In certain circumstances, we may share medical information about you in the course of judicial or administrative proceedings in response to a court or administrative order, or a subpoena, discovery request, or other lawful process.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS

We may release medical information to a coroner, medical examiner, or funeral director when an individual dies.

MULTIDISCIPLINARY PERSONNEL TEAMS

The practice may share health information with a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

YOUR RIGHTS REGARDING MEDICAL INFORMATION

In addition to any rights that you may have under State law, you have the following HIPAA rights regarding medical information that the practice maintains about you.

GET AN ELECTRONIC OR PAPER COPY OF YOUR MEDICAL RECORD

You have the right to inspect and copy medical information that may be used to make decisions about your care.

To inspect and copy medical information, you must submit your request in writing to our Privacy Officer or his/her designee (contact information is set forth at the very end of this notice). If the practice uses or maintains your medical information in an electronic health record (or to the extent that we maintain the information in an electronic form), you have the right to obtain an electronic copy of such information. When information is not readily producible in the electronic form and format you have requested, we will provide you the information in an alternative readable electronic format as we may mutually agree upon, only as readily possible. Furthermore, you have the right to direct the practice to transmit such electronic copy directly to another entity or person that you designate. If you request a copy of the

information, the practice may charge a fee for the costs of copying and/or transmission. The practice will follow State law with regard to approved copying and other associated costs.

The practice may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request. The practice will comply with the outcome of the review.

We are advising you in this notice that if you request that information available in an electronic format be provided via email, that email is an unsecure medium for transmitting information and that there is some risk if medical information is emailed. Information transmitted via email is more likely to be intercepted by unauthorized third parties than more secure transmission channels. If we agree to email you information, you are accepting the risks we have notified you of, and you agree that we are not responsible for unauthorized access of such medical information while it is in transmission to you based on your request, or when the information is delivered to you.

AMEND YOUR MEDICAL INFORMATION

If you feel that your medical information is incorrect or incomplete, you have the right to request an amendment of the information 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 our Privacy Officer (contact information is set forth at the very end of this notice). We may deny your request for an amendment for a number of legally permissible reasons, but we will tell you why in writing within 60 days, and also give you the right to submit a written statement of disagreement with our decision. If you clearly indicate in writing that you want the statement of disagreement to be made part of your medical record, the practice will attach it to your records and include it whenever the practice makes a disclosure of the item or statement you believe to be incomplete or incorrect.

RECEIVE AN ACCOUNTING OF DISCLOSURES

You have the right to request an "accounting of disclosures." This is a list of the disclosures the practice made of medical information about you other than our own uses for diagnosis, treatment, payment and health care operations (as those functions are described above), and certain other disclosures. If, however, the practice is using an electronic health record, the practice will also account for treatment, payment and health care operations made using the electronic health record.

To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer (contact information is set forth at the very end of this notice). Your request must state a time period which may not be longer than six (6) years prior to the date you ask. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within a 12-month period, the practice may charge you a reasonable, cost-based fee for providing the list.

REQUEST RESTRICTIONS ON WHAT WE USE OR SHARE

You have the right to request a restriction or limitation on the use and/or disclosure of your medical information in connection with treatment, payment or heath care operations. You also have the right to request a limit on the medical information the practice shares about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***The practice is generally NOT, however, required to agree to your restriction request.***

In one narrow instance, however, we are required to agree to the request, if all of the following apply: (i) you have requested that we restrict disclosure for payment or healthcare operations purposes; (ii) the disclosure would be made to a health plan/insurer (e.g., we are not precluded from making other allowable disclosures; only disclosures to the health plan/insurer); (iii) the disclosure is not otherwise required by law; and (iv) the medical information restricted pertains solely to a healthcare item or service for which you, or someone on your behalf, have paid us in full (excluding payments

made by the health plan on your behalf) (i.e., you may not restrict the entirety of your medical record from being shared with a health plan/insurer – you may only restrict the portions of your record for those items or services which have been paid in full). You are hereby advised that, even if you utilize this required restriction request and meet the criteria set forth above, the required restriction is ***narrow***. In particular, even if you have requested and received a required restriction, we may still share your information with others for other allowable purposes. **In the event that we make such allowable disclosures, the party to which we have permissibly shared the information with is not bound by the required restriction request that you made to us, and we are not obligated to relay your request to such party. The only way for you to guarantee that such 3rd parties do not then share said information with your insurer/health plan is for you to make a required restriction request with the 3rd party that meets all of the required restriction elements set forth above. We hereby advise you to do so if you desire. Note also that to the extent that you seek follow-up or other treatment from us, and it is necessary for us to include previously restricted PHI when billing your insurer/ health plan for the follow-up treatment (e.g., you have not fully paid out-of-pocket for the service and requested a required restriction), we may share such previously restricted information, but only to the extent that including such PHI is required to support medical necessity of the follow-up care and you do not request a new required restriction/pay out-of-pocket in full for the follow-up care.**

If the practice does agree to comply with non-required requests, the practice will comply with your request unless (a) the information is needed to provide you emergency treatment, or (b) other legal exceptions apply.

To request restrictions, you must make your request in writing to our Privacy Officer (contact information is set forth at the very end of this notice). the practice will not ask you the reason for your request. The practice will attempt to accommodate all reasonable requests.

REQUEST CONFIDENTIAL COMMUNICATIONS

You have the right to request that the practice communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the practice only contact you at work or by mail. The practice will not ask you the reason for your request. We will say "yes" to all reasonable requests. To request confidential communications, you must make your request in writing to our Privacy Officer (contact information is set forth at the very end of this notice).

PAPER COPY OF THIS NOTICE

You have the right to a paper copy of this notice at any time, even if you have agreed to receive this notice electronically.

You may also obtain a copy of this notice at our website:

www.premierendocrine.com

To obtain a paper copy of this notice, ask our front desk staff, or our Privacy Officer (contact information is set forth at the very end of this notice).

BE NOTIFIED IN THE EVENT OF A "BREACH OF UNSECURED PHI"

If, in any case, medical information is used or disclosed in violation of the law, we are required to notify you if the use/disclosure is a "Breach of Unsecured Protected Health Information" (as such terms are defined by the Federal HIPAA Law). We may also be required to notify you pursuant to any State law that may be applicable.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the practice, contact our Privacy Officer in

writing (contact information is set forth at the very end of this notice). We respectfully request that complaints be submitted in writing. ***You will not be penalized or retaliated against for filing a complaint.***

CHANGES TO THE TERMS OF THIS NOTICE

The practice reserves the right to change this notice and our privacy or security policies at any time, and the changes will apply to all information we already have about you. The practice will post a copy of the current/changed notice on our website. The notice will contain the effective date and will be available upon request.

OTHER USES OF MEDICAL INFORMATION/PERMISSIONS/AUTHORIZATIONS

Other uses and disclosures of medical information not covered by this notice or the laws that apply to the practice will be made only with your written permission/authorization. If you provide us permission to use or share medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, this will stop any further use or disclosure of your medical information for the purposes covered by your written authorization, except if the practice has already acted in reliance on your permission. You understand that the practice is unable to take back any disclosures the practice has already made with your permission, and that the practice is required to retain the practice's records of the care that the practice provided to you.

PRIVACY OFFICER CONTACT INFORMATION

If you have any questions about this notice, please contact our Privacy Officer utilizing the contact information set forth below.

Certain provisions of this notice and our related policies and procedures require that notice or other requests be in writing. Please follow our instructions for any such issue.

PRIVACY OFFICER CONTACT INFORMATION

SARAH FISHMAN, M.D.
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Sarah.fishman@premierendocrine.com