Neuroendocrine Associates
Tamara L. Wexler, MD, PhD

Welcome to Neuroendocrine Associates! We ask that you read and sign all the below information. We are happy to answer any questions.

Patient Registration/Financial Responsibility Form

Consent for Medical Treatment. I give consent to Neuroendocrine Associates, PLLC, its staff, physicians and other practitioners (collectively, the "Practice") to provide and perform such medical care, tests, procedures, and other services that are deemed necessary or beneficial by the Practice for my health and well-being.

Financial Agreement. I agree to pay all amounts for which I am financially responsible, in accordance with the rates and terms of the Practice. I understand that the Practice does not participate with any insurance programs and will not submit a claim or seek payment from any third party payors. Therefore, I am required to pay the full amount of services that I receive **in advance** of receiving the services. I may be able to submit a claim to my insurance company for the services provided but my plan may not cover out-of-network services at all, leaving me to pay the full cost, or even if my plan covers out-of-network services, my plan may require higher deductibles and co-insurance for out-of-network care. By signing below, I agree to receive the services from the Practice, even though they may not be reimbursed or fully reimbursed by my insurance plan. I understand that there will be a charge for all returned checks.

I understand that I will be charged a fee of $100.00 if I miss an appointment or fail to cancel an appointment at least 72 hours (business days only) prior to my scheduled visit. I further understand that I must pay this balance in full at the time of my next appointment.

Authorization for Release of Information. By signing below, I authorize the Practice to release my health information: (1) to any requesting health care provider for my further care or treatment or for that provider's payment or health care operation purposes; (2) to any person or entity which may be responsible for billing/collection of claims for medical services; (3) to any person or entity which is, or may be liable for all or part of the Practice' charges, including but not limited to, credit card companies; (4) to any governments agency or other organization responsible for oversight of the Practice; (5) for the Practice' normal health care operations. I authorize the Practice to communicate with me through text or email, even if not encrypted, and to allow the individuals listed above to access such information through any medium including over the Internet, even though the emails may not be encrypted, and through the Practice's electronic medical record system.

I consent to the Practice accessing my medication history information electronically through a secure connection to Superscript, or similar service, using our ePrescribing applications.

I grant permission and consent to the Practice to (1) leave voicemail messages for me, including information regarding amounts owed by me; (2) send me text messages using any wireless telephone numbers I provide; and (3) use pre-recorded/artificial voice messages and/or automatic dialing device in connection with any communications made to me. I understand such calls or contacts could result in charges to me depending on my wireless telephone service plan. The Practice will not be liable for any such charges associated with contacting me as set for above.

Filming. I understand that photographs or other images of me may be recorded for the Practice's treatment and quality assurance purposes. To the extent that such images identify me, I understand that they shall receive the same confidentiality protections as my other health information.

Acknowledgement of Notice of Privacy Notice. I have received a copy of the Practice's Notice of Privacy Practices, and have had the opportunity to receive assistance in the understanding and exercising these rights.

Signature. I have carefully read and fully understand this informed consent form and have had all my questions answered.

_____	_____	_____
Signature of Patient	Print Name	Date

_____	_____
Signature of Patient/legal Representative	Relationship to Patient

Neuroendocrine Associates
Tamara L. Wexler, MD, PhD

HIPAA JOINT PRIVACY NOTICE

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

INTRODUCTION

This Joint Notice is being provided to you on behalf of Dr. Tamara Wexler and the employees and practitioners that work at the Practice with respect to services provided at the Practice (collectively referred to herein as "We" or "Our"). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." (or "PHI") which includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care. We will share PHI with one another, as necessary, to carry out treatment, payment or health care operations relating to the services to be rendered at the Practice.

As required by law, this notice provides you with information about your rights and our duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this Notice as currently in effect, although we reserve the right to change the terms of this Notice from time to time. You can always request a written copy of our most current privacy notice from Dr. Wexler at the Practice or you can access it on our website at www.neuroendocrineassociates.com.

PERMITTED USES AND DISCLOSURES

We can use or disclose your PHI for purposes of *treatment, payment and health care operations*, which we describe below with some examples.

- *Treatment* means the provision, coordination or management of your health care, including consultations and referrals between health care providers relating to your care. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the exercise regimen appropriate for your treatment.

- *Payment* means our activities to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and other utilization review activities. For example, we may need to provide PHI to your Third Party Payor to determine whether the proposed course of treatment will be covered or if necessary to obtain payment.

- *Health care operations* means the support functions of the Practice, related to *treatment* and *payment*, such as quality assurance activities, case management, responding to comments and complaints, compliance programs, audits, business planning, development, and administrative activities. For example, we may use your PHI to evaluate the performance of our staff when caring for you. We may also combine PHI about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose PHI for review and learning purposes. In addition, we may remove information that identifies you so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PHI

We may also use your PHI in the following ways:

- To provide appointment reminders for treatment or medical care.

- To tell you about or recommend possible treatment alternatives or other health-related benefits and services.

- To your family or friends or any other individual identified by you to the extent directly related to such person's involvement in your care or the payment for your care. We may use or disclose your PHI to notify, or assist in the notification of, a family member, or another person responsible for your care, of your location or general condition. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, based upon our professional judgment.

- When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.

- We will allow your family and friends to act on your behalf to pick-up filled prescriptions, medical supplies, and similar forms of PHI, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

- We may use or disclose your PHI for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. When required, we will obtain a written authorization from you prior to using your health information for research.

- We will use or disclose PHI about you when required to do so by applicable law.

- In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or the Practice as required by applicable law.

Note: incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your PHI:

- Organ and Tissue Donation. If you are an organ donor, we may release PHI to organ procurement or transplant agencies as necessary to facilitate organ or tissue donation and transplantation.

- Military and Veterans. If you are a member of the Armed Forces, we may release PHI about you as required by military command authorities.

- Worker's Compensation. We may release PHI for programs that provide benefits for work-related injuries or illnesses.

- Public Health Activities. We may disclose PHI about you for public health activities, including disclosures:
    - to prevent or control disease, injury or disability;
    - to report births and deaths;
    - to report child abuse or neglect;
    - to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to FDA-regulated products or services and to report reactions to medications or problems with products;
    - to notify a person who may have been exposed and may be at risk to a disease.
- Health Oversight Activities. We may disclose PHI to federal or state agencies that oversee our activities (e.g., providing health care, seeking payment, and civil rights).
- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI subject to certain limitations.
- Law Enforcement. We may release PHI if asked to do so by a law enforcement official:
    - In response to a court order, warrant, or summons;
    - To identify or locate a suspect, fugitive, material witness, or missing person;
    - About the victim of a crime under certain limited circumstances;
    - About a death we believe may be the result of criminal conduct;
    - About criminal conduct on our premises; or
    - In emergency circumstances, to report a crime.
- Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroners, medical examiners or funeral director as necessary to carry out their duties.
- National Security and Intelligence Activities. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, other national security activities authorized by law for protection to the President or foreign heads of state.
- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) to provide you with health care; (2) to protect your, and others, health and safety; or (3) for the safety and security of the correctional institution.
- Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

***Note*: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable state and federal law. Any disclosures of these types of records will be subject to these special protections.**

OTHER USES OF YOUR HEALTH INFORMATION

Certain uses and disclosures of PHI will be made only with your written authorization, including uses and/or disclosures: (a) of psychotherapy notes (where appropriate); (b) for marketing; and (c) that constitute a sale of PHI under the Privacy Rule. Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of PHI for treatment, payment and health care operations. We are not required to agree to your request unless the disclosure is to a health plan in order to receive payment, the PHI pertains solely to health care items or services for which you have paid the bill in full, and the disclosure is not otherwise required by law. To request a restriction, you may make your request in writing to the Privacy Officer.
2. You have the right to reasonably request to receive confidential communications of your PHI by alternative means or at alternative locations. To make such a request, you may submit your request in writing to the Privacy Officer.
3. You have the right to inspect and copy the PHI contained in our Practice records. In certain limited circumstances we may be permitted to deny your request without an opportunity to appeal and we will inform you of the basis for such denial. In order to inspect or obtain a copy your PHI, you may submit your request in writing to the Medical Records Custodian. If you request a copy, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

   We may also deny a request for access to PHI under certain circumstances if there is a potential for harm to yourself or others. If we deny a request for access for this purpose, you have the right to have our denial reviewed in accordance with the requirements of applicable law.
4. You have the right to request an amendment to your PHI but we may deny your request for amendment,. In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your PHI, you must submit your request in writing to Medical Record Custodian at our Practice, along with a description of the reason for your request.
5. You have the right to receive an accounting of disclosures of PHI made by us to individuals or entities other than to you for the six years prior to your request, except for certain disclosures precluded by law. To request an accounting of disclosures of your PHI, you must submit your request in writing to the Privacy Officer at our Practice.
6. You have the right to receive a notification, in the event that there is a breach of your unsecured PHI, which requires notification under the Privacy Rule.

COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact the Practice Privacy Officer at info@neuroendocrineassociates.com or (804) 270-5484. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of the U. S. Department of Health and Human Services.

CONTACT PERSON

If you have any questions or would like further information about this notice, please contact the Practice Privacy Officer at info@neuroendocrineassociates.com or (804) 270-5484.

This notice is effective as of August 10, 2020