ELPIS
HEALTHCARE

Summary of Privacy Practices

SUMMARY OF PRIVACY PRACTICES & ASSIGNMENT OF BENEFITS:

The official Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information. Please refer to that Notice for further information: We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing/accreditation, and training of students. **Uses and Disclosures Base on your authorization:** Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. **Uses and Disclosures, Not requiring your authorization:** In the following circumstances, we may disclose your health information without your written authorization: 1.) to family members or close friends who are involved in your health care. 2.) For certain limited research purposes. 3.) For purposes of public health and safety. 4.) To Government agencies for purposes of their audits, investigations, and other oversight activities. 5.) To government authorities to prevent child abuse or domestic violence. 6.) To the FDA to report product defects or incidents. 7.) To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders. 8.) When required by court orders, search warrants, subpoenas and as otherwise required by law. **Patient Rights:** As our patient, you have the following rights: 1.) to have access to and/or a copy of your health information. 2.) To receive an accounting of certain disclosures we have made of your health information. 3.) To request restrictions as to how your health information is used or disclosed. 4.) To request that we amend your health information. 5.) To receive notice of our privacy practices.

I hereby authorize the above-named insurance company/companies to assign directly all benefits payable. I make this an irrevocable assignment of benefits. I understand that any insurance checks issued belong to ELPIS Healthcare PLLC, and/or their subsidiary companies, for services rendered and I agree to endorse them over should I receive them or otherwise repay any amounts paid to me. Failure to do so would result in legal action. I(we) am (are) aware that if payment is not made within a reasonable amount of time by the insurance carrier(s), that the and the matter is submitted to a collection agency/attorney, I (we) will be responsible for payment of all costs associated with that collection activity, including but not limited to reasonable attorney's fees, and court costs. I fully understand that once the account is being past due the practice reserves the right to begin adding interest at 1% per month simple interest, and if sent to collection, I (we) will be responsible for costs for collection agents and/or reasonable attorney's fees and/or costs of litigation.

ASSIGNMENT OF BENEFITS & LTD. POWER OF ATTORNEY: I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my

behalf for services rendered to me. I direct that all reimbursable medical payments go directly to you, my medical provider. In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case in my name including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and or your attorney to obtain medical information regardin g my physi cal condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

CONSENT FOR TREATMENT:

At my request, the undersigned hereby voluntarily consents to undergo health screening tests performed by our medical provider. I understand that it is not possible to diagnose or define any disease or problem with a single test alone, and that a screening cannot detect every health problem. I understand that the test results will be reported directly to me. I further understand that it is my responsibility to consult the medical doctor for interpretation analysis, evaluation, and further explanation of my test results. I understand that the medical providers will only review instant results with patients. I understand that the medical provider or ordering physicians shall be liable for any claims including, but not limited to, any claim arising out of or related to, inaccurate, un-interpreted, misinterpreted or results not received and do hereby expressly forever release and discharge all claims, demands, injuries, damage, actions or cause of action.

I understand that the test results will become part of my medical record. I also understand that an insurance company may discover the results of this testing by obtaining a copy of my medical record in accordance with the terms of insurance policy(ies). I hereby consent to the release of my blood test results to me in a manner that I have chosen and my physician or any other health care provider I designate. I understand that my test results will only be provided to other third parties upon my express consent.

All of the above has been discussed with me and I have had an opportunity to have any questions answered that I have regarding my rights to Privacy. I understand possible but infrequent side effects include fainting, bacterial infection, or bruising (hematoma) at the puncture site are possible. In rare circumstances, I may be contacted for redraw due to poor lab sample. I understand some tests are for screening purposes only and are not diagnostic tests or substitutions for a more complete examination by a physician. Blood test results can fluctuate from day to day due to changes in the individual and from Laboratory variation. If any of my results fall outside normal ranges, I understand that I should see the physician for a follow up evaluation.

Media Release:

I hereby give my consent to all photographs, audio recordings, academic work, and/or video recordings taken of me. I understand that any such photographs, audio recordings, academic work, and/or video recordings become the property of the event producer and may be used with consent, for educational, instructional, or promotional purposes determined by the producer in broadcast and electronic media formats now existing or in the future created**. I also understand that I will be notified verbally, prior to any photographs, audio and/or video taken for final consent.**

I acknowledge that I have received, read, and understand the Summary of Privacy Practices and Health Screening Consent.

Signature:_____ **Printed Name:**_____ **Date:**_____