PRIME BODY

ACHIEVE YOUR OPTIMAL BALANCE

Patient Forms & Guidelines

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Male Patient Questionnaire & History

Name:_____ Today's Date:_____
(Last) (First) (Middle)

Date of Birth:_____ Age:_____ Occupation: _____

Home Address: _____

City:_____ State:_____ Zip: _____

Home Phone:_____ Cell Phone:_____ Work: _____

E-Mail Address:_____ May we contact you via E-Mail? ( ) **YES** ( ) **NO**

In Case of Emergency Contact:_____ Relationship: _____

Home Phone:_____ Cell Phone:_____ Work: _____

Primary Care Physician's Name:_____ Phone: _____

Address: _____
Address City State Zip

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

In the event we cannot contact you by the mean's you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name:_____ Relationship: _____

Home Phone:_____ Cell Phone:_____ Work: _____

Social:

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) I have used steroids in the past for athletic purposes.

Habits:

( ) I smoke cigarettes or cigars_____ a day.
( ) I drink alcoholic beverages_____ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine_____ a day.

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Medical History

Any known drug allergies: _____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No
If yes please explain: _____

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Other Pertinent Information: _____

_____

Medical Illnesses:

( ) High blood pressure.
( ) High cholesterol.
( ) Heart Disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Hemochromatosis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.
( ) Cancer (type): _____
Year: _____

( ) Testicular or prostate cancer.
( ) Elevated PSA.
( ) Prostate enlargement.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.

I understand that if I begin testosterone replacement with any testosterone treatment, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone treatment should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

Print Name	**Signature**	**Today's Date**

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BHRT CHECKLIST FOR MEN

Name: _____ **Date:** _____

E-Mail: _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in general well being				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Other symptoms that concern you:

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Insurance and HRT

Many people who have inquired about our services have asked us why we do not bill insurance or other third party payers directly, when other healthcare providers do. At PrimeBody, we are committed to a healthcare model that puts the patient first and is free of the "big insurance" influence. We fully understand the financial challenge this presents to some patients and we wish there were a way for us to bill your insurance company. Unfortunately, at this time, there isnot.

When clinics bill health insurance companies directly, a doctor is required to become a participating provider. The doctor then must sign a contract that allows the insurance company to determine which services they will and will not provide. In general, insurance companies are not presently focused on most preventative or wellness services. Furthermore, the current insurance driven model of health care is often forced to rely on quantity of patients seen instead of the quality of the patientinteraction.

As you are aware, we are a non-participating provider with Medicare, Medicaid, Tricare, and other third party payersandinsurancecompanies. If you belong toan HMO, Medicare, Medicaid, Tricare, or other third party payer program, you must pay outofpocket forall therapy costs generated byour office and you are not permitted to submit your out of pocket costs for reimbursement.

Disclaimer of Medicare/Private Insurance Benefit

Patient acknowledges that PrimeBody has made no representation or warranty that the treatment or any portion thereof qualifies or will qualify for reimbursement or assignment under Medicare, Medicaid and/or any other federal/state government or private insurance program.

Patient hereby covenants to PrimeBodythat he or she **shall not** submit any claim(s) to Medicare, Medicaid, or any other government program for any portion of the treatment at any time and agrees to indemnify PrimeBody and its members and managers against any claim, action, loss or suit and associated costs (including attorney's fees) which result either directly or indirectly from submission by patient (or his or her authorized agent or representative) of a claim for any portion of the treatment to Medicare, Medicaid, or other federal/state government benefit program.

Patient acknowledges that this agreement was executed before services were rendered, and that patient is not facing an urgent or emergency health situation.

Patient's Full Name (print) Date

Patient's Signature

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Telemedicine Patient Consent Form

PATIENT NAME: _____

DATE OF BIRTH: _____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure(s) and/or service(s)
   - Bioidentical Hormone Replacement Therapy
   - Testosterone Replacement Therapy
   - Weight Loss
2. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation:
   a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
   d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)
3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.
4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Arizona state law apply to information disclosed during this telemedicine consultation.
5. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in Arizona, and that Arizona law shall apply to all disputes.
7. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telemedicine consultations for the procedure(s) described above.

Patient's Full Name (print) Date

Patient's Signature

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Medical Care/ Medication Management Agreement

This agreement between _____(Patient's Name) and PrimeBody (PB) establishes guidelines and conditions required for the proper use of Hormone Replacement Therapy (HRT).

PB and patient agree that these guidelines and conditions are an essential factor in maintaining a successful patient/physician relationship.

The patient accepts and agrees to all the following conditions (1-12):

1. I agree that the PB patient/physician relationship is not intended to replace the existing patient/physician relationship with my current Primary Care Provider (PCP). I also understand that I am contracting with PB for specific HRT conditions only, and that any other medical problems I may experience now, or in the future, must be diagnosed and treated by my own physician.
2. I agree to contact PB 4-6 weeks into the start of my therapy (and every 3-4 months thereafter) to arrange for any follow-up blood testing and/or an office visit/consultation as required and I agree this work will be 100% self-pay, and not reimbursable by any private or governmental third party payer..
3. I understand that the hormone replacement therapy I have undergone is prescribed for me based on diagnoses derived from my submitted medical history, blood/lab work, and a physical examination. They are to be used exclusively for treatment of these diagnoses. I agree that I will use my medications at the prescribed rate and dosage.
4. Although adverse reactions to any of the products or medications recommended by PB are rare and uncommon, I will immediately report any adverse side effects related to the use of my medication to PB and discontinue use until advised to resume usage by PB.
5. I understand that PrimeBody representatives are available for questions and/or concerns during normal business hours (9am-5pm M.S.T., Mon-Fri) throughout the course of my treatment.
6. **IN CASE OF EMERGENCY, IMMEDIATELY CONTACT A PHYSICIAN OR GO TO AN EMERGENCY ROOM.**
7. I will not attempt to obtain "scheduled" hormone replacement therapy medications illegally or receive hormone replacement therapy from another healthcare practitioner without disclosing my current medication usage.
8. I agree that these medications are for my personal use only and no other purpose. I will not share, sell, or trade my medications.
9. I will safeguard my medications from loss or theft and will be responsible for their safekeeping. Furthermore, I will keep the medication in its respective labeled container.
10. I will not use my prescribed medications for "anti-aging", body building or as a performance enhancement substance.
11. PB wishes to provide consistent, quality care to each patient. In this regard, we recommend specific compounds of medications which are formulated by select compounding pharmacies approved by PB. Each compounding pharmacy approved by PB passes a series of stringent third-party tests to validate the purity, potency, sterility and absence of toxins. These pharmacies also have the ability to produce and readily provide our prescribed delivery methods, strengths, quantities and supplies needed for our patients to safely and consistently administer and reconstitute the physician's recommended treatment. **Our office receives discounted physician medication pricing. This discount still represents a lower price from what atypical patient would pay for the same products as a retail customer. Patients may obtain medications from another provider; however alternative professional fees may apply in order to adjust therapy protocols on an individual basis.** For patient safety and therapy continuity, PB reserves the right to deny a provider if they cannot meet the compounding criteria of one or more individualized prescriptions.
12. I will check my shipment(s) as soon as it arrives for completeness and accuracy. All discrepancies must be reported to PrimeBody and the compounding pharmacy within 48 hours.

Patient's Full Name (print) **Date**

Patient's Signature

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Consent to Treatment

I.) The Nature of the Treatment

I hereby give my consent to evaluation and treatment of andropause, /stress, menopause and other hormone imbalances by the administration of Hormone Replacement Therapy ("HRT") and/or nutritional supplements, including vitamins, minerals and anti-oxidants and/or drugs designed to alter hormone levels. The nature of the procedure is to raise levels of hormone in my body to levels which will improve quality of life, as well as functional ability, the goal of which being to decrease the incidence of sickness and disease. The exception to raising hormone levels involves the modulation of insulin and/or cortisol levels to the lower 33% of the normal range for the patient age.

II.) Alternative Treatment Approach

The reasonable alternatives to these therapies have been EXPLAINED to me and they include, but are not limited to:

- **MAINTAINING CURRENT HORMONE LEVELS**
- **TREATING CHRONIC (PERSISTENT) DISEASES AS THEY OCCUR**
- **TREATING SYMPTOMS WITH NON BIO-IDENTICAL MEDICATION(S)**

III.) The General Nature and Extent of Treatment-Related Risks

Most hormone deficiencies are indicated by symptoms and may implicate the potential for illness when certain hormone levels are too high or low. Along with my doctor, I believe that it is when hormones are within a safe range to reduce my unwanted symptoms, that we will obtain the optimum goal in my health.

In andropause, men gradually lose their ability to produce testosterone and some men develop elevated levels of estrogen. As men undergo an ever-increasing loss of testosterone, they are faced with anxiety, irritability, erectile dysfunction, bone loss, muscle loss, loss of strength, and loss of energy and memory impairment.

Possible side effects of male testosterone replacement include, but are not limited to: unwanted hair growth, enlargement of the prostate, loss of sperm production (sterility), enlargement of breast tissue, testicular atrophy (shrinking), acne, oily skin and hair, and in some studies, an increased risk of prostate cancer growth.

With respect to adrenal function, my doctor has explained the risks of adrenal therapy with me including the long term use of corticosteroid (cortisol) which has been associated with osteoporosis. I understand that my doctor will use other methods to help reestablish my own adrenal hormone production, but that this may involve the short term use of cortisol. In addition, I will be informed of long term complications if my doctor and I feel that long term use of cortisol is indicated.

In hypothyroidism, studies have shown that physicians may under-treat this condition. I understand that my physician will be working with me to suppress my symptoms and improve my quality of life by considering my symptoms as well as my thyroid hormone levels to monitor the treatment of my disease. I understand that the potential side effects in using thyroid medication including osteoporosis, palpitations, dizziness, psychiatric problems (mania), and elevated or irregular heart rate.

With respect to age and the incidence of Adult Growth Hormone Deficiency Syndrome, I appreciate that there are certain risks associated with the use of human growth hormone. While growth hormone has been shown to increase muscle mass, lower fat mass and improve bone density, the clinical guidelines for the diagnosis and treatment of such a hormone loss have yet to be clearly established. Therefore, my physician at PrimeBody and I have discussed the benefits of human growth hormone and the associated risks. These risks include: water retention, which may result in leg swelling and elevated blood pressure, mild increase in fasting blood sugar and occasional bruises at the injection site. I may also develop infection at the injection site if I use improper technique. Most all of these side effects are reversible by dosage adjustment or discontinuing therapy.

In menopause, women lose the majority of their hormones within a few years, causing in many cases, severe distress, both mental and physical. Through the use of hormone replacement therapy, one can counter this decline and help alleviate the symptoms due to menopause. Additionally, studies now indicate that hormone therapy is effective in the treatment of osteoporosis, as well as other disease process associated with hormone decline as we age.

The potential adverse effects for women using estrogen, progesterone and/or testosterone include, but are not limited to: breast swelling and/or discomfort, fluid retention, dizziness, palpitations, break through bleeding, requiring an endometrial biopsy, acne, unwanted hair growth, oily skin and hair, and headache.

I also understand that if I am female and become pregnant, I should discontinue the entire treatment protocol immediately and notify Your physician. I understand that this hormone therapy is not for the purpose of preventing pregnancy. If I should become pregnant during the course of therapy, there are potential risks to the fetus (unborn child).

I understand that I need to get blood work evaluated and reviewed by a licensed Physician no less than 3 times annually so the Physician can determine if it's in the patient's best interest to continue the therapy.

IV.) Safety of Hormone Replacement

Although in my physician's opinion, the majority of data points toward safety, no one has yet proven or has yet disproven a causal relationship between the use of hormone therapy and cancer. I understand that careful surveillance and close monitoring are requirements of all patients to minimize any possible risk.

I understand there are other studies that point to a higher incidence of cancer in patients who take Hormone Replacement Therapy. However, these studies, which show an association (two variables present simultaneously), do not demonstrate cause and effect. I realize that it may be a number of years before we know if there is any true cause and effect between hormones and increased risk for cancer in women or men.

I understand that although each hormone has been approved by the Food and Drug Administration ("FDA") for use in the treatment of certain diseases. I also understand that the FDA only approves or disapproves of products made by manufacturers which are produced in an established dosage and form. Therefore by definition, the FDA does not "approve" or "disapprove" of hormones which are given in an individual dose and in an appropriate form for each patient as determined by my doctor at PrimeBody. I also understand that my doctor may choose to discuss with me and provide to me medications that are off-label in order to offer to me the widest range of therapies possible. ("Off-label" use means the use of FDA approved drugs for purposes other than those for which the FDA has approved them.) "Off-label" prescribing is a legal and common practice by physicians in the United States. A recent study found that more than 20% of overall prescription drugs in the U.S. and close to 50% of drugs in some specialties are used in an off-label manner.

V.) Administering the hormones; Remedies; Termination of Treatment

Any questions I have regarding this treatment have been answered to my satisfaction. I understand that I will be responsible for administering the hormones prescribed to me. I will conform and comply with the recommended dose and methods of administration. I also agree to conform to the request for initial and subsequent blood tests, as required to monitor my hormone levels. I understand that failure on my part to follow my physician's recommendations in dosage and use of my hormones and medication may result in unwanted and potentially harmful side effects/results. I understand that failure to have appropriate laboratory testing completed at the interval established by my physician and failure to follow up with my physician a t the recommended appointments may lead also to adverse (unwanted) side effects.

I also understand there are possible benefits associated with these procedures. I understand that no guarantee has been made to me regarding outcomes neither of this treatment nor on resolution of my symptoms. I understand that not all patients receive the same degree of response. I also understand that the benefits derived from therapy will cease and those derived from hormone therapy and drugs that alter hormone levels may not reverse if the therapy is discontinued.

I authorize PrimeBody to perform this treatment. I understand they may be assisted by other health professionals, as necessary, and agree to their participation in my care as it relates to nutritional supplementation and hormone modulation therapy. I certify that I am under the regular care of another physician for all other medical conditions. I understand that this is a specialized practice and does not hospitalize patients. I also understand that I will continue under the care of my other physician(s) for any ongoing medical condition as well as for any medical consultation that I may need.

I ASSUME FULL LIABILITY FOR ANY ADVERSE EFFECTS THAT MAY RESULT FROM NON-NEGLIGENT ADMINISTRATION OF THE PROPOSED TREATMENT. I WAIVE ANY CLAIM IN LAW OR EQUITY FOR REDRESS OF ANY GRIEVANCE THAT I MAY HAVE CONCERNING OR RESULTING FROM THIS PROCEDURE, EXCEPT AS THAT CLAIM PERTAINS TO NEGLIGENT ADMINISTRATION OF THE PROCEDURE.

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Consent to Treatment

I hereby confirm that the nature and purpose of portions of the aforementioned treatment are considered by some to be medically unnecessary and/or experimental, as there are no long-term studies documenting the results. The risks involved and the possibilities of complications have been explained to me. I fully understand that some aspects of the treatment to be provided may be considered experimental and unproven by scientific testing and peer-reviewed publication. I understand that I may suspend or terminate treatment at any time and hereby agree to immediately notify PrimeBody's physician of any such suspension or termination.

The undersigned certifies that HE/SHE has read and understands all the above, and as the Patient, agrees to and accepts the terms. I acknowledge I have been encouraged to ask any questions regarding this therapy. To attest to MYFULL, COMPETENT, ANDINFORMED CONSENT to this treatment, I hereby affix my signature to this Consent to Treatment.

Patient's Full Name (Print) **Date**

Patient's Signature

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Patient Consent for the Use & Disclosure of Health Information

I understand that as part of my health care, PrimeBody's staff originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis to my bill,

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that PrimeBody is not required to agree to the restrictions requested, other than my request to restrict disclosure to third party payers regarding services for which I have independently paid in full. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that PrimeBody reserves the right to change their notice and practices and prior to impel-mentation, in accordance with Section 164.520 of the Code of Federal Regulations. If PrimeBody changes its privacy notices, we will issue a revised notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information PrimeBody maintains. I understand that I may obtain a copy of PrimeBody's Notice of Privacy Practices, including revisions of Notice, at any time by contacting PrimeBody at: 15950 N 76th St. Scottsdale, AZ 85260 or calling (844) 845-BHRT (2478)

If there is any person(s) in which you authorize to receive treatment or account status, please list name and relationship provided here:

NAME: _____ **PHONE** _____

NAME: _____ **PHONE** _____

I have had full opportunity to read and consider the contents of this Consent form and Prime Body's Notice of Privacy Practices. I understand that as part of treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these uses as permitted bylaw.

Patient/Guardian _____ **Date** _____

Print Name of Person Signing _____

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR PROTECTED HEALTH INFORMATION. PLEASE READ CAREFULLY.

As an essential part of our commitment to you, PrimeBody maintains the privacy of certain confidential health care information about you, known as Protected Health Information (PHI). Your PHI is information about you or information that could be used to identify you, as it relates to your past and present physical and mental health. State law and the Health Insurance Portability and Accountability Actof1996 (HIPAA) require us to maintain the confidentially of all your healthcare records and other individually identifiable health information used by or disclosed to us electronically, on paper or orally.

We realize that these laws are complicated, but PrimeBody is required to provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

In most situations PrimeBody may use this information as described in this Notice without your permission or authorization, but there are some situations where PrimeBody may use it only after we obtain your written authorization for use or disclosure. PrimeBody professional and non-professional staff will abide the terms of the Notice.

We respect your privacy and treat all health care information about our patients with care under strict policies of confidentiality that we are committed to following at all times.

How PrimeBody may use and disclose medical information about you

The following are the ways PrimeBody may use and disclose your PHI with examples of each use:

For Treatment: This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided by us and other medical professionals. For example, we may disclose your PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care.

For Payment: This includes any activities we undertake in order to receive payment for the services we provide to you and, third party financing and collection of outstanding accounts.

For our Administration and Health Care Operations: This includes activities necessary for our continuing operation such as quality assurance, licensing, and training programs to ensure that our personnel meet our standards of care, following established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints. We may also create reports that do not individually identify you for data collection purposes. **For Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services**: This includes use and disclosure of your PHI to contact you and remind you that you have an appointment with us. We may also tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

As Required by Law: PrimeBody is required to use or disclose your PHI as required and limited by law.

To a Family Member, Friend, or Other Person Involved in Your Health Care: This includes the use and disclosure of your PHI to family members or close friends if we obtain your agreement to do so, or if given the opportunity to object, you do not. We may also disclose your PHI to family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to disclosure when you allow a family member in the examination room for discussion, evaluation, or treatment.

For Public Health Activities: We may use and disclose your PHI for public health activities. These activities usually include disclosures for the purpose of preventing or controlling disease, injury, or disability and reporting instances of disease, injury and vital statistics such as birth or death. Other public health disclosures could be made for the purposes of reporting communicable or sexually transmitted diseases, reporting reactions to medication or problems with products, and notifying people of recalls of products they may be using.

To Report a Suspected Case of Abuse, Neglect ,or Domestic Violence: This includes the use or disclosure of your PHI To a government authority, including a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

For Health Oversight Activities: This includes the use or disclosure of your PHI to a health oversight agency for oversight activities authorized by law, including audits; civil or criminal investigations; inspections, licensure or disciplinary action.

For Legal and Administrative Proceedings: This includes the use and disclosure of your PHI to respond to a court order, a subpoena, discovery request, or other lawful process, provided that proper documentation is presented to us

For Law Enforcement Purposes: This includes the release your PHI at the request of law enforcement officials for the purpose of: reporting certain types of wounds or physical injuries; responding to a court-ordered warrant, subpoena, or a grand jury subpoena; identifying or locating a suspect, fugitive, material witness, or missing person; reporting persons suspected to be victims of crime; and reporting crime in emergency situations

To Coroners, Medical Examiners, and Funeral Directors: This includes PHI used or disclosed to a coroner or medical examiner for the purpose of identifying a deceased person or determining cause of death, or to funeral directors as necessary to carry out their duties with respect to the decedent.

For Organ, Eye, or Tissue Donation: If you are an organ donor, we may use or disclose your PHI to organizations that handle organ procurement or other entities engaged in procurement such as banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation and transplantation.

To Avert a Serious Threat to Health or Safety: This includes the use and disclosure of your PHI, if we believe in good faith, and is consistent with any applicable law and standards of ethical conduct, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. Disclosures will only be made to someone who may be able to help prevent the threat

For Specialized Government Functions: This includes the use and disclosure of your PHI if you are military personnel or foreign military personnel. Other use and disclosure may be for national security and intelligence activities, protective services, correctional institutions, and law enforcement custodial situations.

For Workers' Compensation: This includes disclosure of your PHI as authorized by and to the extent necessary to comply with law relating to workers' compensation or other similar programs that provide benefits for work-related injuries without regard to fault.

For Disaster Relief Purposes: This includes the use or disclosure of your PHI to a public or private entity authorized by law to assist in disaster relief effort.

Inactive Patient Records: We will retain your records for seven years from your last treatment or examination, at which point you will become an inactive patient in our practice and we may destroy your records at that time. We will do so only in accordance with the law (e.g., in a confidential manner, with a Business Associate agreement prohibiting re-disclosure if necessary).

Collections and Marketing: If we use or disclose your PHI for marketing (i.e., communications that encourage recipients to purchase or use a product or service) or collections purposes, we will do so only in accordance with the law.

<u>Your rights regarding medical information:</u>

You may access your medical information: To access your medical information, you must submit your request to us at our address listed below. If you request copies, we may charge a fee allowed by law. We may deny your request in certain very limited circumstances. For example, we might deny access to psychotherapy notes that may be a part of your record.

Under the HITECH regulation, if we have use e-health records, then we must provide an individual with a copy of his or her PHI in electronic record format. If this electronic transfer occurs, we may only charge for the labor involved.

You may amend or correct your medical information: You may ask us to amend or correct your medical information. Please make your request in writing and submit it to our office address listed below. You must provide a reason that supports your request.

You may request an "accounting of disclosures": You may request a list of the disclosures we made of medical information about you, other than for treatment, payment or practice operations as described above, and without your written authorization.

You may request restrictions on the use or disclosure of your medical information: You may request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or Practice operations. For example, you could ask that we not share information with a family member or friend about surgery you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. You may also request that your health information not be submitted to your health insurance carrier if you intend to pay for your services in full at the time of your treatment.

You may request confidential communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

We will try to accommodate all reasonable requests.

You may have a paper copy of this Notice: You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of this Notice at any time, even if you obtained a copy electronically.

Breach Notification

The HITECH Act requires that we notify patients whose PHI has been breached. A breach occurs when an unauthorized use or disclosure that comprises the privacy or security of PHI presents a significant risk for financial, reputational or other type of harm to the individual.

PrimeBody's Business Associate Agreements have been amended per the HITECH law to provide that all HIPAA security safeguards, etc. apply directly to the business associate.

Revisions to the Notice of Privacy Practices

PrimeBody reserves the right to change and/or revise this Notice of Privacy Practices. We reserve the right to make the changed Notice effective for medical information we already know about you, as well as any information we receive in the future. If we make changes, we will post the changed Notice, along with its effective date, in our office. Also, upon request, you will begiven a copy our current Notice.

Exercise of privacy rights and complaints

Mail or fax to us your writtenrequestsformodifyingorcancellingaconfidentialcommunication, for copies of your records, or for amendments to your record.

You may file a complaint with us by notifying our Privacy Officer of your complaint. You may also file a complaint to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

If you have any questions, wish to file a complaint, or exercise any rights listed in this Notice, please contact:

PrimeBody
Privacy Officer
14500 N. Northsight Blvd Suite 100
Scottsdale, AZ 85260
Call: 844-845-BHRT (2478)

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave.,
S.W. Washington, DC
20201
Call: (877) 696-6775 (toll free)

Patient Initials _____