



### Formulario de Paciente

#### Demografía

Nombre del Paciente: \_\_\_\_\_ [ ] Hombre [ ] Mujer [ ] Otro

Fecha de Nacimiento: \_\_\_\_\_

Número de Seguro Social del Paciente \_\_\_\_\_

Etnicidad: \_\_\_\_\_ Idioma Preferido: \_\_\_\_\_

Diagnostico Actual (si corresponde): \_\_\_\_\_

Nombre (Persona completando este formulario): \_\_\_\_\_

Relación al Paciente: \_\_\_\_\_

Dirección de Casa: \_\_\_\_\_

Teléfono Primario: \_\_\_\_\_ Teléfono Secundario: \_\_\_\_\_

Contacto de Emergencia: \_\_\_\_\_ Relación: \_\_\_\_\_ Teléfono: \_\_\_\_\_

#### Información del Doctor

Médico Primario: \_\_\_\_\_ Teléfono: \_\_\_\_\_

Médico de Referencia: \_\_\_\_\_ Teléfono: \_\_\_\_\_ Especialidad: \_\_\_\_\_

#### Información del Seguro/Insurance Information

Tipo de Seguro Primario/*Primary Insurance Type*:

Tipo de Seguro Secundario/*Secondary Insurance Type*:

Número de Miembro/*Member ID Number*: \_\_\_\_\_

Número de Miembro/*Member ID Number*: \_\_\_\_\_

Número de Grupo/*Group Number*: \_\_\_\_\_

Número de Grupo/*Group Number*: \_\_\_\_\_

Nombre del Titular/*Policy Holder's Name*:

Nombre del Titular /*Policy Holder's Name*:

Fecha de Nacimiento del Titular/*Policy Holder's DOB*:

Fecha de Nacimiento del Titular/*Policy Holder's DOB*:

Seguro Social del Titular/*Policy Holder's Social Security #*:

Seguro Social del Titular/*Policy Holder's Social Security #*:

#### Información del Guardián

Nombre del Guardian/*Guardian Name*: \_\_\_\_\_

Nombre del Guardian/*Guardian Name*: \_\_\_\_\_

Relación al Paciente/*Relationship to Patient*: \_\_\_\_\_

Relación al Paciente/*Relationship to Patient*: \_\_\_\_\_

Fecha de Nacimiento/*Date of Birth*: \_\_\_\_\_

Fecha de Nacimiento/*Date of Birth*: \_\_\_\_\_

Número de Seguro Social/*Social Security #*: \_\_\_\_\_

Número de Seguro Social/*Social Security #*: \_\_\_\_\_

Estado Civil/*Marital Status*: \_\_\_\_\_

Estado Civil/*Marital Status*: \_\_\_\_\_

Ocupación/*Occupation*: \_\_\_\_\_

Ocupación/*Occupation*: \_\_\_\_\_

Teléfono de Casa/*Home Phone*: \_\_\_\_\_

Teléfono de Casa/*Home Phone*: \_\_\_\_\_

Celular/*Cell Phone*: \_\_\_\_\_

Celular/*Cell Phone*: \_\_\_\_\_

Teléfono de Trabajo/*Work Phone*: \_\_\_\_\_

Teléfono de Trabajo/*Work Phone*: \_\_\_\_\_

Correo Electrónico/*E-mail Address*: \_\_\_\_\_

Correo Electrónico/*E-mail Address*: \_\_\_\_\_

## Motivo Principal de la visita de hoy

Por favor describa sus preocupaciones principales. (¿Cuánto tiempo ha notado sus preocupaciones?)

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¿Ha tratado de resolver estas preocupaciones? [ ] Si [ ] No

¿Fueron efectivos sus intentos? [ ] Si [ ] No [ ] No está seguro/a

¿Hubo un evento que ha causado que usted busque tratamiento? [ ] Si [ ] No [ ] No está seguro/a

## Lista Actual de Síntomas

[ ] Humor depresivo/ Con tristeza

[ ] Incapacidad para disfrutar los placeres de la vida

[ ] Problema de sueño

[ ] Falta de interés

[ ] Falta de concentración

[ ] Pensamientos incontrolables/Acelerados

[ ] Impulsividad

[ ] Energía excesiva

[ ] Aumento en irritabilidad

[ ] Episodios de llanto

[ ] Preocupación excesiva

[ ] Ataques de ansiedad

[ ] Aislamiento

[ ] Comportamientos repetitivos

[ ] Pensamientos de dañar alguien más

[ ] Aumento en comportamiento arriesgado

[ ] Aumento de la libido

[ ] Necesidad reducida de sueño

[ ] Otro: \_\_\_\_\_

¿Alguna vez has tenido sentimientos o pensamientos de que no quieres vivir? [ ] Si [ ] No [ ] No está seguro/a

¿En este momento sientes que no quieres vivir? [ ] Si [ ] No [ ] No esta seguro/a

¿Con qué frecuencia tienes estos pensamientos? \_\_\_\_\_

¿Cuándo fue la última vez que has tenido estos pensamientos? \_\_\_\_\_

¿Ha ocurrido algo recientemente que ha causado que te sientas de esta manera? [ ] Si [ ] No [ ] No está seguro/a

¿Habrá algo que pueda mejorar cómo te sientes? [ ] Sí [ ] No

¿Has planeado como te quitarías la vida? [ ] Si [ ] No

¿El método que usarías está fácilmente disponible? [ ] Yes [ ] No

¿Has planeado el tiempo para completar el plan? [ ] Si [ ] No

¿Hay algo que te previene de quitarte la vida? [ ] Si [ ] No

¿En el pasado has intentado quitarte la vida ó dañarte a ti mismo? e.g. autolesiones? [ ] Sí [ ] No

## Historial Medico

Fecha del Examen físico más reciente: \_\_\_\_\_

Por favor de marcar los problemas significativos o relevantes, eso incluye diagnósticos y las edades cuando fueron diagnosticados.

[ ] Conmoción Cerebral [ ] Problemas de Vision [ ] Problemas Auditivos [ ] Convulsiones

Ha sido tratado/a por otros profesionales? [ ] Yes [ ] No

Medicamento actual:

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Historial Médico (E.g lesiones, cirugías, hospitalizaciones, diagnosticos):

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Alergias:

**Para Mujeres**

¿Está embarazada o piensa en embarazarse? [ ] Si [ ] No [ ] No estoy segura

¿Planea embarazarse en un futuro cercano? [ ] Si [ ] No [ ] No estoy segura

Método de anticonceptivo: \_\_\_\_\_

Por favor marque todos los medicamentos **historiales**

**Antidepresivos/Antidepressants**

- Prozac (fluoxetine)
- Zoloft (sertraline)
- Luvox (fluvoxamine)
- Celexa (citalopram)
- Lexapro (escitalopram)
- Paxil (paroxetine)
- Pristiq (desvenlafaxine)
- Cymbalta (duloxetine)
- Effexor (venlafaxine)
- Wellbutrin (Bupropion)
- Remeron (mirtazapine)
- Viibryd (vilazodone)
- Trintellix (vortioxetine)
- Elavil (amitriptyline)
- Anafranil (clomipramine)
- Sinequan (doxepin)
- Tofranil (imipramine)
- Pamelor (nortriptyline)
- Other: \_\_\_\_\_

**Ansiolítico (Anxiolytics)**

- Xanax (alprazolam)
- Buspar (buspirone)
- Ativan (lorazepam)
- Vistaril (hydroxyzine)
- Klonopin (clonaxepam)
- Valium (diazepam)
- Librium (chlordiazepoxide)
- Tranxene (clorazepate)
- Other: \_\_\_\_\_

**Antipsicóticos/ Antipsychotics**

- Thorazine (chlorpromazine)
- Haldol (haloperidol)
- Other: \_\_\_\_\_

**Antipsicóticos atípicos/Atypical Antipsychotics/Mood Stabilizers**

- Abilify (aripiprazole)
- Clozaril (clozapine)
- Latuda (lurasidone)
- Zyprexa (olanzapine)
- Seroquel (quetiapine)
- Risperdal (risperidone)
- Geodon (ziprasidone)
- Haldol (haloperidol)
- Prolixin (fluphenazine)
- Other: \_\_\_\_\_

**Estabilizadores/ Mood Stabilizers**

- Lithium
- Tegretol (carbamazepine)
- Neurontin (gabapentin)
- Lamictal (lamotrigine)
- Trileptal (oxcarbazepine)
- Topamax (topiramate)
- Depakote (valproate)
- Other: \_\_\_\_\_

**Sedantes/ Sedatives/Sleep Aides**

- Ambien (zolpidem)
- Sonata (zaleplon)
- Rozerem (ramelteon)
- Restoril (temazepam)
- Desyrel (trazodone)
- Other: \_\_\_\_\_

**TDAH/ ADHD**

- Adderall (amphetamine)
- Adderall XR
- Concerta (methylphenidate)
- Ritalin (methylphenidate)
- Daytrana (methylphenidate)
- Metadate (methylphenidate)
- Evekeo (amphetamine)
- Dyanavel XR (methylphenidate)
- Strattera (atomoxetine)
- Quillivant XR
- Vyvanse (lisdexamfetamine)
- Focalin (dexmethylpheniate)
- Other: \_\_\_\_\_

**Historial de Familia** (Por favor indique cualquier familiar que haya sido diagnosticado o que ha tenido experiencia de lo siguiente)

	Madre/ <i>Mother</i>	Padre/ <i>Father</i>	Hermano(a) <i>/Sibling</i>	Abuelos Maternal/ <i>Materna</i> l <i>Grandparents</i>	Abuelos Paternal/ <i>Paternal</i> <i>Grandparents</i>	Otro/ <i>Other</i>
Depresión						
Ansiedad						
Abuso de sustancias						
Discapacidad de aprendizaje						
TDAH/ADHD						
Trastorno Bipolar						
Psicosis/ Esquizofrenia						
Trastorno obsesivo						
Comportamiento Suicida						
Auto-lesiones						
Trastorno de Convulsiones						
Espectro Autista						
Discapacidad Intelectual						
Abuso						
Problema de tiroide						
Otro						

**Historia Psiquiátrica**

¿Has recibido cualquiera de los servicios?

- Terapia Individual: [ ] Si [ ] No
- Terapia Familiar: [ ] Si [ ] No
- Terapia de Grupo: [ ] Si [ ] No
- Examen Psicométricos: [ ] Si [ ] No
- Hospitalización Psiquiátrica: [ ] Si [ ] No
- Ideación Suicida en el pasado: [ ] Si [ ] No
- Comportamiento Agresivo o Ideación Homicida: [ ] Si [ ] No
- Diagnóstico Previo: [ ] Si [ ] No

**Abuso de Substancia**

¿El abuso de sustancia es una preocupación primaria? [ ] Si [ ] No

Anteriormente, ha sido tratado/a por abuso de alcohol o drogas? [ ] Si [ ] No

¿Cuánto días a la semana toma alcohol? \_\_\_\_\_

¿Cuántas bebidas alcohólicas es lo mínimo que toma en un día? \_\_\_\_\_

¿Cuántas bebidas alcohólicas es lo máximo que toma en un día? \_\_\_\_\_

En los últimos tres meses, ¿Qué ha sido lo más que ha tomado en un día? \_\_\_\_\_

¿En algún momento has pensado que deberías beber menos o reducir el uso de drogas? [ ] Si [ ] No

¿Le ha molestado la gente criticando su consumo de alcohol o drogas? [ ] Si [ ] No

¿En algún momento se ha sentido mal por su uso de alcohol o drogas? [ ] Si [ ] No

¿Alguna vez ha tomado o usado drogas a primera hora del día para calmar sus nervios? [ ] Yes [ ] No

¿Ha usado drogas callejeras en los últimos 3 meses? [ ] Si [ ] No

¿Alguna vez ha abusado de medicamentos recetado? [ ] Si [ ] No

### ***Historia del Tabaco***

¿Alguna vez ha fumado cigarros? [ ] Si [ ] No

¿En este momento fuma cigarros? [ ] Yes [ ] No

¿Cuántos paquetes por día? \_\_\_\_\_

### ***Historia de Trauma***

¿Ha tenido experiencia o presenciado algún tipo de abuso? [ ] Sí [ ] No

- Abuso emocional: [ ] Si [ ] No
- Abuso físico : [ ] Si [ ] No
- Abuso sexual [ ] Si [ ] No
- Negligencia: [ ] Si [ ] No

### ***Educacion***

¿Cuál es el nivel de educación más alto que ha completado? \_\_\_\_\_

### ***Historia de Ocupación***

En este momento está: [ ] Trabajando [ ] Estudiando [ ] Sin empleo [ ] Deshabilitado [ ] Retirado

- ¿Cuánto tiempo lleva en su ocupación presente? \_\_\_\_\_
- ¿Cuál es su ocupación actual? \_\_\_\_\_
- ¿Dónde trabaja? \_\_\_\_\_
- ¿Cuál es su horario de trabajo? \_\_\_\_\_

### **Historial de Familia y Relaciones:**

[ ] Casado/a por: \_\_\_\_\_

[ ] Soltero/a por: \_\_\_\_\_

[ ] Divorciado/a por: \_\_\_\_\_

[ ] Viudo/a por : \_\_\_\_\_

[ ] Unido/a por: \_\_\_\_\_

¿Como identifica su orientación sexual? \_\_\_\_\_

[ ] Prefiero no contestar

Esta sexualmente activo/a [ ] Si [ ] No

¿Ha tenido matrimonios anteriores? [ ] Si [ ] No

¿Tiene hijos? [ ] Si [ ] No

¿Cuáles son las edades y donde viven? \_\_\_\_\_

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¿Vive usted con alguien? \_\_\_\_\_



Elite DNA Therapy Services, LLC  
General Consent for Treatment

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Consent for Treatment

I hereby voluntarily give my consent for myself, my child, or my family to receive one or more of the following services or treatments provided by Elite DNA Therapy Services, LLC: Psychiatry, Psychotherapy, Medication Management, Occupational Therapy (OT), Speech Therapy (ST), Advanced Behavioral Analysis (ABA), Transcranial Magnetic Stimulation (TMS), Mental Health, or Substance Abuse and Addiction Medicine services, all within the professional medical judgement and discretion of Elite DNA Therapy Services, LLC's doctors, nurse practitioners, and staff. I further consent to the collection and use of past and current medical and medicine history of patient, patient's family, patient's providers, including pharmacies from which prescriptions have been obtained. I consent to the use of photography for purposes of verifying identification of patients and/or identifying accompanying persons. Because I have the right to refuse services at any time, I understand and agree that my or my family's continued participation in services or treatments offered by Elite DNA Therapy Services, LLC implies informed consent. If I choose to revoke this consent, I understand that providers and/or clinic staff may not be able to provide to me, my child, or family members necessary services and treatments that have been recommended. I further understand that Elite DNA Therapy Services, LLC participates in educational programs and that students in these affiliated programs may be involved in care provided.

\_\_\_\_\_ (initials) I understand that potential benefits of undergoing services offered by Elite DNA Therapy Services, LLC may include improvement in functioning of myself or child and/or an increased understanding of myself and/or child. I understand that potential risks may include possible disagreement with opinions offered to me, and possible emotional distress concerning my situation. I understand that alternative procedures may include services provided by other psychologists, psychiatrists, or mental health professionals.

\_\_\_\_\_ (initials) I understand that while the evaluation and/or treatment will be based upon known principles and research, the practice is not an exact science. I acknowledge that no guarantees have been made to me concerning the results of evaluations and/or treatments or services provided by Elite DNA Therapy Services, LLC.

\_\_\_\_\_ (initials) I verify that I am the patient OR patient's legal guardian per Florida State Statute Chapter 744 for the above and furthermore certify that the information, records, and other documents I have provided to Elite DNA Therapy Services, LLC (either verbally or in writing) are accurate to the best of my knowledge.

\_\_\_\_\_ (initials) I hereby acknowledge that I have reviewed the Notice of Privacy Practice(NPP) and the Patients' Rights and Responsibilities documents. I can request copies. Elite DNA Therapy Services, LLC must post NPPs. Signed copies of consents, agreements, and authorizations can be used in place of original scanned into medical record chart.

By signing below, I am agreeing to consent for treatment and my understanding of the information described in this document. I have read this consent and have been able to ask questions.

\_\_\_\_\_

Printed Name of Patient or Guardian

\_\_\_\_\_

Relationship to Patient

\_\_\_\_\_

Signature of Patient or Guardian

\_\_\_\_\_

Date

Consent for Treatment

Created: 06/18

Elite DNA Staff Initials: \_\_\_\_\_ CLIN-004(form)

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**Elite DNA Therapy Services, LLC**  
**Permission to Discuss Protected Health Information (PHI)**  
**Others Who are Involved in Your Healthcare**  
(Not to Be Used as Authorization to Release Information)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby permit Elite DNA Therapy Services, LLC to share specific information described below, only for the purposes and persons involved in my healthcare.

Description of the specific information to be discussed:

Appointment Date/Times                       Summary of Medical Record                       Pick Up Prescriptions  
 Diagnosis     Care Plan     Other (specify): \_\_\_\_\_  
 Medications Lab Tests/Results                       Genetic Testing Results

Indicate Confidential Information you **don't want discussed**:

Mental Health                       Medication     HIV information                       Alcohol/Drug Information

Information provided to:

Full Name: \_\_\_\_\_ Full Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**It is my responsibility to inform Elite DNA Therapy Services, LLC of changes and to revoke and complete another form.**

I understand that:

- This document does not dictate that our providers will initiate conversations or other methods to share information with persons listed above. If those persons wished to be involved, then it is their duty to initiate involvement, and if time and circumstances permit, then Elite DNA Therapy Services, LLC will do our best to comply to your wishes.
- I may revoke this permission in writing by contacting our office manager or Privacy Officer.
- Information shared may be subject to re-disclosure by the recipient and no longer be protected under HIPAA.
- **This document is intended to relieve burden of our staff to know to whom you want to involve in this patient's care. It is not mandatory to complete.**
- **This document is not an authorization to release protected health information (PHI).**
- **Information Excluded from the Right of Access: Psychotherapy notes, which are the personal notes of a mental health care provider documenting or analyzing the contents of a counseling session, that are maintained separate from the rest of the patient's medical record. (45 CFR 164.524(a)(1)(i) and 164.501)**

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Printed Name of Patient or Guardian

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Relationship to Patient

---

Signature of Patient or Guardian

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Date

Permission to Discuss Protected Health Information  
(PHI) Created: 06/18  
PRIV-002(form)

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**Elite DNA Therapy Services, LLC**  
**General Policies, Insurance Assignments, and Financial Agreement**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**General Policies**

\_\_\_\_\_ (initials) **Emergency Services** – Elite DNA Therapy Services, LLC is not a 24-clinic and WE DO NOT PROVIDE EMERGENCY SERVICES. For emergencies call 911 or go to nearest emergency room. For non-life-threatening after-hours services, please call the office and follow prompts.

\_\_\_\_\_ (initials) **Missed/Cancelled Appointments** – A patient who fails to appear or cancels less than 24 hours in advance of an appointment may be subject to a \$40 fee and may be discharged. The first appointment with the psychiatrist for an initial evaluation is critical. If you miss this evaluation you may not be able to reschedule the appointment for a 6-month period. Please remember to reschedule ahead of time and we will attempt to accommodate your requests. Since “things happen,” patients will be permitted to miss one appointment in a 6-month period without being penalized. However, please know that repeated “no-shows” may jeopardize your ability to receive treatment.

\_\_\_\_\_ (initials) **Lateness** – Due to stringent billing requirements, we will be unable to see patients who are late for their appointment. Please call to let us know if you are running late and we will attempt to reschedule your appointment, as needed. However, you may be subject to a \$40 fee or suspension of services if you are not able to maintain your appointments.

\_\_\_\_\_ (initials) **Absence for More than 6 Months** – If you cancel or miss your appointments for longer than a 6-month period, you may be considered a new patient and another intake appointment may be necessary. Also, you may be placed on a waiting list.

\_\_\_\_\_ (initials) **Communications** – You understand that you may receive calls from Elite DNA Therapy Services, LLC or third-party business associates for purposes of including, but not limited to, results communication, patient surveys, and debt collection using the phone numbers, including wireless numbers you have provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

\_\_\_\_\_ (initials) **Confidentiality and Release of Protected Health Information (PHI)** – All information disclosed within sessions is confidential and may not be revealed to anyone outside of the Elite DNA Therapy Services, LLC without written permission, except for disclosures as required by law. The law does require clinicians to report to the authorities any reasonable suspicions of child or elder abuse, or danger of harm to self and/or to others unless protective measures are taken. To the extent necessary to determine insurance benefits or liability for payment and to obtain reimbursement, Elite DNA Therapy Services, LLC may disclose portions of the patient’s medical record and account file to any person or corporation that may be liable for all or any portion of the patient’s charges, including but not limited to insurance companies, health care service plans or workers’ compensation carriers. Elite DNA Therapy Services, LLC may disclose information to referring provider following the minimum necessary rule.

**Insurance Assignments**

\_\_\_\_\_ (initials) **Fees for Clinical Services** – At Elite DNA Therapy Services LLC, we accept many insurance plans, single case agreements, and private pay. Please inquire about our fees, as the rates may be different depending on which provider you are seeing. Please know that you may be billed for telephone calls, written reports or other services that specifically require the provider’s time outside of scheduled appointments.

\_\_\_\_\_ (initials) **Assignment of Insurance Benefits** – In consideration of services rendered, I hereby transfer and assign to Elite DNA Therapy Services, LLC all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance.

\_\_\_\_\_ (initials) **Medicare / Medicaid** – I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me may send to responsible carriers, or their intermediaries, any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treatment me.

**Financial Agreement**

\_\_\_\_\_ (initials) **Payment Responsibility** – I understand that insurance claims are filed as a courtesy. If a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the provider for services rendered to the patient. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges. I authorize direct payment to be made to Elite DNA Therapy Services, LLC for all services and treatments rendered. I understand if any services or treatments charges are not covered by my insurance carrier or my eligibility cannot be verified, I am responsible for all charges incurred. Furthermore, it is an agent or patient’s responsibility to know insurance coverage for services, as some services and general medical coverage may be provided by two separate plans. I understand that it is my responsibility to pay any co-pay, deductible, co-insurance, or any other balance not paid for by insurance or third-party payor within a reasonable time not to exceed 30 days. If you are considered the guarantor, you will provide your name, Date of Birth, and Social Security Number to satisfy requirements to bill insurance companies. Our office staff is happy to help answer questions and help with this process.

\_\_\_\_\_ (initials) **Financial Agreement** – The signatory agrees, whether signatory signs as agent or as patient, that in consideration of services to be rendered to patient, signatory obligates them to pay charges for services received in accordance with regular rates and terms of Elite DNA Therapy Services, LLC. We reserve the right to assign unpaid bills to a collection agency. Should your account be referred to an attorney for collections, the signatory should pay reasonable attorney’s fees and collection expense. If you have any questions about by this agreement, please feel free to ask for clarification.

**The signatory certifies that he or she has read, understands, and accepts these terms and conditions of this document and is either the patient or is duly authorized by the patient as patient’s general agent to execute the above agreement and may receive a copy upon request.**

\_\_\_\_\_  
Printed Name of Patient or Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

You have the right to request copies of all signed documents. General Policies, Insurance Assignments, and Financial Agreement.

# Elite DNA Therapy Services, LLC

## Notice of Privacy Practices

### Purpose:

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review this notice carefully.

### Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information (IIHI) or Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. At Elite DNA Therapy Services, the privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. Our practice will also post a copy in our office in a visible location always.

### Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation  A source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy
- Better understand who, what, when, where, and why others may access your health information

- Make more informed decisions when authorizing disclosure to others

### Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- Request to amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

#### Right to A Copy of Your Medical Records

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A “designated record set” contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. To inspect and copy medical information that may be used to make decisions about you, you must contact the office to obtain an Authorization Form. Once you have received this form, please fill it out thoroughly and send the form back to the office.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed.

#### Right to Request Restrictions

You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Please discuss any restriction you wish to request with your physician. You may request a restriction by contacting the office for a “Request of Restrictions Form”. This form must be submitted to our office.

### Right to Amend

This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to obtain the "Health Record Amendment Form". This form must be submitted to our office.

### Right to Receive Certain Accounting Disclosures

This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. Please contact our Privacy Officer to obtain the "Request for Accounting Disclosures Form". This form must be submitted to our office.

### Right to Obtain A Paper Copy

You are entitled to receive a paper copy of our notice of privacy practices. To obtain a paper copy of this notice, please contact the Office.

### Our Responsibilities

Elite DNA Therapy Services, LLC is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

### How We May Use and Disclose Your Information Treatment

For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

## Payment

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

## Healthcare Operations

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used to continually improve the quality and effectiveness of the healthcare and service we provide.

## Business Associates

There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

## Appointment Reminders

We may contact you by phone or leave a message on your home, work or cell phone as a reminder that you have an appointment scheduled for medical care at the office. Please notify us if you do not wish to be contacted for appointment reminders.

## Notification

We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

## Communication with Family Members

Health professionals, using their best judgment, may disclose to a family member, other relative, close friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

## Research

We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

## Disclosures Required by Law

We may use or disclose your protected health information to the extent that the use or disclosure is required by federal, state, or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

## Military and National Security

When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for a determination by the Department of Veterans Affairs of your eligibility for



benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

#### Workers' Compensation/Health Oversight Activities

Your Protected Health Information may be disclosed by us as authorized to comply with Workers' Compensation laws and other similar legally-established programs.

We may disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

#### Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your medical information in response to a court or administrative order. We may also disclose your medical information in response to a subpoena.

#### Coroners, Medical Examiners and Funeral Directors

We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death.

#### Other Uses and Disclosures of Health Information

We will not use or disclose your Protected Health Information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization in writing at any time. If you revoke the Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. We cannot release your

Psychotherapy Notes without a special signed, written authorization (different than the Authorization mentioned above) from you. To disclose these types of records for purposes of treatment, payment or health care operations, we will have to have a special written authorization that complies with the law.

#### Food and Drug Administration (FDA)

We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

#### Correctional Institution

Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

#### Complaints (Anonymous Hotline Number

888.453.3114) There will be no retaliation for filing a complaint.

If have questions and would like additional information, you may contact our Privacy Officer at 239.223.2751

If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer at 239.223.2751 or [privacy@elitednatherapy.com](mailto:privacy@elitednatherapy.com).

OR with the Secretary of Health and Human Services by using the information below:

Timothy Noonan, Regional Manager

Office for Civil Rights

U.S. Department of Health and

Human Services Sam Nunn

Atlanta Federal Center, Suite

16T70 61 Forsyth Street, S.W.

Atlanta, GA 30303-8909

Customer Response Center: (800) 368-1019

Fax: (202) 619-3818

TDD :(800) 537-7697

Email: [ocrmail@hhs.gov](mailto:ocrmail@hhs.gov)

This revised notice was published and becomes effective on January 30, 2018.