

NOTE ON PATIENT CONFIDENTIALITY

By Federal law, without your authorization, your protected health information (including but not limited to the results of your Health Risk Assessment) may NOT be disclosed to third parties except for the purposes of treatment, payment or health care operations or for public health or the safety, and will NOT be disclosed to your employer.

The steps outlined below are intended to provide brief notes regarding Activate Clinic's approach to protecting the privacy and security of individually identifiable health information.

Steps taken to ensure this outcome:

- The Clinic operates according to privacy and security processes mandated by state and federal law
- The Clinic uses an electronic medical record protected by both access and authentication controls consistent with the National Institute of Standards in Technology requirements. No one can access Protected Health Information without satisfying appropriate multifactor security protections and only Activate personnel have access to such controls
- Data does not reside on personal computers—only in the secure web server in a remote and protected location
- All computer maintenance, cleaning, etc., is managed by outside contractors not the Employer
- The Activate Clinic premises is protected by a special security system and only Activate staff members have access to the Clinic Premises after hours

Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health (HITECH) Act and the regulations promulgated to implement them, the Activate Clinic has implemented a *Notice of Privacy Practices*, which describes Activate Clinic's approach to the privacy and security of Protected Health Information.

CONFIDENTIAL MEDICAL HISTORY AND STATUS SHEET

Date of Birth: _____

Name: _____ Age: _____ Date: _____

Address: _____
Street City State Zip

Married: Single: Divorced: Phone Number: _____

Email Address: _____ Preferred method of Contact (circle one): phone/email

In the future, may we text you with non-medical communications (e.g. appointment confirmation): yes/no

Preferred Pharmacy: _____ Social Security Number: _____

Insured Work Location and/or Department: _____ Dept. Phone/extn: _____

Allergies (to what substance and type of reaction): _____

Current Medications and Dosages (please include over-the-counters, vitamins, minerals, and herbs):

- 1) _____ 5) _____
- 2) _____ 6) _____
- 3) _____ 7) _____
- 4) _____ 8) _____

Present or Previous Medical Conditions (please check all that apply):

- | | | |
|---|--|---|
| 1. <input type="checkbox"/> High blood pressure | 9. <input type="checkbox"/> Brain/nerve injury/disease | 19. <input type="checkbox"/> Overweight (or Weight gain) |
| 2. <input type="checkbox"/> Diabetes | 10. <input type="checkbox"/> Seizure Disorder | 20. <input type="checkbox"/> Vision problems |
| 3. <input type="checkbox"/> High cholesterol
(Total, LDL, lipids, or fats) | 11. <input type="checkbox"/> Asthma
(Shortness of Breath) | 21. <input type="checkbox"/> Hearing problems |
| 4. <input type="checkbox"/> Low HDL (good cholesterol) | 12. <input type="checkbox"/> COPD | 22. <input type="checkbox"/> Heartburn (Reflux) |
| 5. <input type="checkbox"/> Heart disease
(heart pain/attack) | 13. <input type="checkbox"/> Cancer | 23. <input type="checkbox"/> Abdominal pain |
| 6. <input type="checkbox"/> Heart rhythm problems | 14. <input type="checkbox"/> Arthritis | 24. <input type="checkbox"/> Blood in stools/black BM's |
| 7. <input type="checkbox"/> Blood vessel disease
(blockages) | 15. <input type="checkbox"/> Depression | 25. <input type="checkbox"/> Unexplained bleeding |
| 8. <input type="checkbox"/> History of stroke/TIA | 16. <input type="checkbox"/> Anxiety | 26. <input type="checkbox"/> Sexual dysfunction
(decreased interest/ability) |
| | 17. <input type="checkbox"/> Thyroid disease | 27. <input type="checkbox"/> Other |
| | 18. <input type="checkbox"/> Fatigue (Tiredness) | |

Please list the item number from above with further information (such as type of cancer or arthritis) and dates of diagnosis, treatment, and/or hospitalizations: _____

Information given is entered in the electronic medical record used for risk-assessment and medical treatment purposes only.



PATIENT CONSENT AND AUTHORIZATION FORM

(Please Read and Sign)

I, _____, hereby consent and authorize Activate Healthcare, PC to provide me with the services listed on the attached description of Activate Services. In the provision of Activate Services, I consent and authorize Activate Healthcare, PC to provide:

- Administration and performance of all relevant diagnoses and treatments
- Performance of such procedures as may be deemed necessary or advisable in my treatment
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended.

I understand that **ACTIVATE HEALTHCARE, PC** may rely upon this Patient Consent and Authorization Form at satellite offices under common ownership and services provided in support of Activate Healthcare, PC by its manager Activate Healthcare, LLC.

I, the undersigned, authorize **ACTIVATE HEALTHCARE, PC** to use, receive and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices. Specifically, by executing this Consent and Authorization Form I knowingly authorize and intend to permit Activate Healthcare PC to use and release protected health information to other healthcare providers and to my health plan as necessary, and to permit other healthcare providers and my health plan to release the necessary protected health information to Activate Healthcare, PC, as necessary for Treatment, Payment and Healthcare Operations.

I SPECIFICALLY AUTHORIZE ACTIVATE HEALTHCARE, PC TO RELEASE INFORMATION ABOUT MY PARTICIPATION IN WELLNESS PROGRAMS TO MY EMPLOYER, TO BE USED FOR THE PURPOSE OF VALIDATING MY ELIGIBILITY FOR INCENTIVES.

This authorization is valid twelve months from the below date.

A photocopy of this consent shall be considered as valid as the original.

I acknowledge that I have been given the **ACTIVATE HEALTHCARE, PC** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Officer.

I certify that I have read and fully understand the above statements, consent and authorization fully and voluntarily to its contents.

Printed Patient Name Date of Birth

Patient Signature Date of Signature



HIPAA COMMUNICATIONS AND DISCLOSURES AUTHORIZATION

The federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act (“HITECH”) a subpart of the American Recovery and Reinvestment Act of 2009 (“ARRA”) and the implementing regulations regarding the privacy and security of individually identifiable health information (45 CFR Parts 160 and 164) promulgated thereto (collectively, the “Laws”) require patient authorization for certain uses of such patient’s individually identifiable health information (“Protected Health Information” or “PHI”). While the Laws permit, generally, the use and disclosure of PHI for treatment, payment and operations, Activate Healthcare, PC requests formal authorization from each patient to enable its legitimate use of PHI, in all cases.

I, _____,
authorize **ACTIVATE HEALTHCARE, PC** to receive, use and/or disclose my Protected Health Information for the purposes of Treatment, Payment, and Healthcare operations as described in the Notice of Privacy Practices.

Specifically, by executing this Authorization Form I intend to permit Activate Healthcare PC to use and release my Protected Health Information to other third parties, healthcare providers and to my health plan as necessary for Treatment, Payment and Healthcare Operations under the Laws.

Moreover, I authorize other third parties, healthcare providers and my health plan to release my Protected Health Information to Activate Healthcare, PC, as necessary for Treatment, Payment and Healthcare Operations under the Laws.

I acknowledge and agree that Activate may use or disclose, as appropriate any and all information in its possession, including information relating to any medical history, mental, behavioral or physical condition, including drug or alcohol conditions, and any diagnosis or treatment about or received by me.

Communication with Patient: I specifically authorize Activate to communicate with me using the confidential contact information provided below for that purpose and using the Twine and other applications. I understand that Protected Health Information will only be communicated using secure means, such as Twine and the Activate Patient Portal.

Twine Messages: I understand that Activate provides an Activate Patient Portal and Twine application, both of which allow patients to input data, such as weight or blood sugar or blood pressure, and, using Twine, to send **Non-Urgent** messages to their providers and allows Activate providers to send messages back to patients.

I understand that Twine is **only** for **Non-Urgent** matters. I understand that Activate Providers do **not** have access to Twine except when they are in the Activate Clinic.

Activate Providers will attempt to respond to all Twine Messages and Alerts within two (2) business days. Activate Providers will only respond to Twine Messages and Alerts, and cannot otherwise monitor information provided by patients through Twine or the Activate Patient Portal.

Activate Providers cannot and **will not** respond to emergency or urgent messages, alerts or conditions, using Twine or the Activate Patient Portal.

If I have an emergency condition or an urgent problem, I will call 911 right away.

Further, pursuant to this authorization, I authorize any uses or disclosures not mentioned herein, but otherwise required by law.

I acknowledge that I have been given the **ACTIVATE HEALTHCARE, PC** Notice of Privacy Practices. I understand that if I have questions or complaints about this Authorization or about the privacy practices of **Activate Healthcare, PC** that I should contact the Privacy Officer at privacy@activatehealthcare.com.

I certify that I have read and fully understand the Authorization fully, have the opportunity to ask questions about it and voluntarily agree to its contents.

Patient Signature

Date of Signature

Confidential Contact Information.

Authorized Personal (not work or shared) address, email and phone number for Confidential Communications with Patient:

Mailing Address: _____

Email Address: _____

Telephone Number: _____

Activate may ___/ may not ___ leave a telephone voice message using the telephone number provided.

Signature of Patient's Representative (if for minor patient), Relationship to Patient, Date



HIPAA Patient Checklist

Patient Name: _____

Date of Birth: _____

Spouse, family members, or other persons involved in your care that can be given medical information about you by this office, or contacted in the event of an emergency.

A. _____ Relationship: _____
Phone Number(s): _____

B. _____ Relationship: _____
Phone Number(s): _____

C. _____ Relationship: _____
Phone Number(s): _____

D. _____ Relationship: _____
Phone Number(s): _____

E. Power of Attorney (POA) for Medical _____
Phone Number(s) of POA: _____

Privacy Information: Please circle YES or NO for the following statements. By circling YES for the following statements this office will leave answering machine messages at your home, work or emergency contact that may include your protected health information and that may be overheard by others not involved in your care.

Table with 3 columns: Place, Call Back Message, Detailed Message. Rows: Home, Work, Emergency Contact.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

This form will remain in effect from the date of the signature. Any changes to this form must be submitted on a new form by the patient and witnessed.