Northeastern Pulmonary Associates, LLC

M. Saud Anwar, M.D, MPH FCCP *Faustinus C. Onyirimba, M.D, FCCP*
Saima Ansari, M. D *Heather Shah, A.P.R.N. DNP*

Your appointment is on _____, with _____.
Please bring this completed paperwork, with your insurance cards(s) and photo I.D. Please arrive 15 minutes before your appointment time. We will need to update/create a chart for you.
Thank you and we look forward to helping you breathe better!

You may visit our website to download new patient paperwork & directions to our office
www.northeasternpulmonary.org

*DIRECTIONS TO **VERNON** OFFICE* 27 Naek Road, Unit 2 Vernon, CT 06066 ***From the West:*** Take route 84 East Take exit 64/65 (Dual exit) Take your 2nd right off exit onto Route 83 North (Talcottville Road) Take your 3rd left onto Naek Road (approximately 1 mile) Take left into second driveway (at first brick building) #27 Naek Road Proceed to the end (corner of building) and park	***From the East:*** Take 84 West Take exit 65 Turn left off the exit onto Route 30 West (Hartford Turnpike) Continue to the next light and take right onto Dobson Road Go to the light and take a right onto Route 83 (Talcottville Road) Go approximately 1 mile and take your first left onto Naek Road Take left into second driveway (at first brick building) #27 Naek Road Proceed to the end (corner of building) and park ***If you are coming from Rockville Hospital area on Union Street:*** You will travel West on Union & then Union will turn into Route 83 (Talcottville Road) Go approximately 3 miles and take right onto Naek Road Take left into second driveway (at first brick building) #27 Naek Road Proceed to the end (corner of building) and park

27 Naek Road, Unit 2, Vernon, CT, 06066
Telephone (860) 875-2444 Fax (860)872 -2936

Northeastern Pulmonary Associates, LLC

Patient Information (Please Print)

Patient Name: _____ Home Phone: _____
Address: _____ Cell Phone: _____
City: _____ State: _____ Zip: _____ Work Phone: _____
Date of Birth: _____ Driver's License # _____
Social Security Number: _____

Birth SEX: M F (Circle) Marital Status: S M D W Separated (Circle)

Primary Language Spoken: _____
Race: _____ Ethnicity: _____
Emergency Contact: _____ Relationship to Patient: _____
Emergency Phone # _____ Pharmacy: _____
Primary Care Physician: _____ Pharmacy Address: _____
Referring Physician: _____ Pharmacy Phone#_____

INSURANCE INFORMATION

Primary Insurance
Name of Insurance Co: _____
ID# _____
Group# _____
Name of Insured: _____
Employer: _____
Relationship to Insured: Self Spouse Child Other (please circle) OBJ

Secondary Insurance
Name of Insurance Co: _____
ID# _____
Group# _____
Name of Insured: _____
Employer: _____
Relationship to Insured: Self Spouse Child Other (please circle)

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Northeastern Pulmonary, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions.

Patient Signature: _____ Date: _____

MEDICARE AUTHORIZATION

I request the payment of authorized Medicare benefits be made either to me or on my behalf to Northeastern Pulmonary for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize the release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the Insurer or agency shown. For Medicare assigned cases the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _____ Date: _____

Northeastern Pulmonary Associates, LLC
Patient History

Date: _____ Physician: _____
Patient Name: _____ Age: _____
Date of Birth: _____ Sex: M F Race: _____

Reason for visit: _____
Source of Referral: _____
List of all physicians you see: _____
_____
Presenting Complaint(s):

1. _____
2. _____
3. _____
4. _____

History of Presenting Complaint(s):
Severity: _____
Timing: _____
Duration: _____
Quality: _____
Context: _____
Modifying Factors: _____
Location: _____
Associated Signs/Symptoms: _____
Other: _____

Past Medical History: _____
_____
_____
_____
_____
_____
_____

Please Circle Yes or No if you have any of the following medical problems:

Diabetes…….	YES	NO	Gastrointestinal Problems…….	YES	NO
Bleeding Disorder……..	YES	NO	Genitourinary Problem……	YES	NO
Cancer……..	YES	NO	Cardiac Problems…….	YES	NO
Stroke……	YES	NO	Infectious Diseases……..	YES	NO

Medications:

Medication	*Dosage*	*Frequency*	*Duration*

Allergies:

Drug/Agent	*Reaction Type*

Past Surgical History:

Social History:

Smoking: Age Started: _____ Age Ended: _____ Average/day: _____

Alcohol: Amount/day: _____ Other Drugs: _____ Amount: _____

Exercise: _____

Marital Status (circle) Married Divorced Separated Widowed Single

People Living in Household: _____

Age of House/Building: _____

Exposure to chemicals and dusts outside workplace: _____

Hobbies: _____

OCCUPATIONAL HISTORY:

Job Title and Duration of Services	*Company & Location*	*Exposures & Duration Day/week/yr. Protection*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Job Status: _____

Source of Income: _____

Family History: Circle appropriate and List Medical Problems

Father: Alive / Deceased	*Mother: Alive / Deceased*	*Siblings: Brothers____ Sisters ____*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Choice of Hospital for Admission: _____

Advanced Directives: _____
_____
_____

Power of Attorney: _____
_____

REVIEW OF SYSTEMS: Please circle YES or NO if you have any of the following

Constitutional	*Allergic/Immunologic*	*Eyes*

Good General Health	YES	NO	Indoor Allergies	YES	NO	Glaucoma	YES	NO
Recent Weight Change	YES	NO	Seasonal Allergies	YES	NO	Blurred/Double Vision	YES	NO
Night Sweats/Fevers	YES	NO	Food Allergies	YES	NO	Watery Eyes	YES	NO
Fatigue	YES	NO	Medicine Allergies	YES	NO			

Ears/Nose/Mouth/Throat			***Gastrointestinal***			***Integumentry (Skin/Breast)***		
Nose Bleeds	YES	NO	Nausea/Vomiting	YES	NO	Rashes/Itching	YES	NO
Congestion	YES	NO	GERD	YES	NO	Breast Lump	YES	NO
Postnasal Drip	YES	NO	Abdominal Pain	YES	NO	Breast Pain/Discharge	YES	NO
Sore Throat	YES	NO	Rectal Bleeding	YES	NO			
Voice Change	YES	NO	Black Tarry Stools	YES	NO			
Sinus Problems	YES	NO				Hematologic/Lymphatic		
Hearing Loss or Tinnitus	YES	NO	***Genitourinary***			Excessive Bleeding	YES	NO
Other	YES	NO	Blood in Urine	YES	NO	Enlarged Glands	YES	NO
			Kidney Stones	YES	NO	Easy Bruising	YES	NO
			Sexual Problems	YES	NO	Excessive Clotting	YES	NO

Respiratory			***Endocrine***			***Neurological***		
Cough up Blood	YES	NO	Excessive Thirst/Urination	YES	NO	Frequent Headaches	YES	NO
Shortness of Breath	YES	NO	Thyroid Disease	YES	NO	Convulsions/Seizures	YES	NO
Wheezing	YES	NO	Excessive Hair Growth	YES	NO	Numbness/Tingling	YES	NO
Dyspnea on Exertion	YES	NO	Excessive Eating	YES	NO	Paralysis/Tremors	YES	NO
Cough	YES	NO	Feeling Cold/Hot	YES	NO			

Cardiovascular			***Musculoskeletal***			***Psychiatric***		
Chest Pain	YES	NO	Muscle Pain	YES	NO	Depression	YES	NO
Palpitations	YES	NO	Joint Pain	YES	NO	Insomnia	YES	NO
Murmur	YES	NO	Stiffness/Swelling	YES	No	Anxiety	YES	NO
Swelling of Feet	YES	NO	Difficulty Walking	YES	NO			

PREVENTIVE PULMONARY MEDICINE

Smoking Cessation _____
Osteoporosis _____
Glucose _____
PPD (TB TEST) _____
Pneumovax _____
Flu Vaccine _____

Patient Statement: To the best of my knowledge, the above information is accurate and complete

Signed: _____ Date: _____

Physician Statement: I have reviewed the questionnaire with the patient:

Signed: _____ Date: _____

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would affect you. Use the following scale to choose the most appropriate number for each situation:

0= No chance of Dozing
1= Slight Chance of Dozing
2= Moderate Chance of Dozing
3= High Chance of Dozing

SITUATION	CHANCE OF DOZING
Sitting and Reading	
Watching TV	
Sitting Inactive in a public place (e.g. theater, meeting, etc.)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Northeastern Pulmonary Associates, LLC

DIRECTIONS TO OUR OFFICE

27 Naek Road, Unit 2
Vernon, CT 06066
(860) 875-2444

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Take exit 65
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No Show & Cancellation Policy

We must have 24-48 hours (1-2 days) notice of Cancellation of appointment. If we do not have the required cancellation notice time, you will be charged a fee of $50.00 as a late cancellation.

No Shows are also charged a fee of $50.00 for missed appointments and $150.00 for missed testing appointments and New patient appointments (they are 45 minute appointments)

We currently have a waiting list of patients for appointments……. If you cannot make your appointment, please notify us so we can give someone else that appointment time

Thank you for your cooperation

~Referrals~

If your insurance requires referrals to see a specialist, it is *YOUR responsibility* to obtain a referral from your primary care physician. If you are seen and do not have a referral, you will be billed for our services. Please check your insurance card &/or call your health plan to see if you are required to obtain a referral to see a specialist.

*(** Some United Healthcare policies require referrals from your primary care physician**)*

~Office Copays~

Copays are due upon arrival for your scheduled appointment. You may pay your copay in cash, credit card or bank card. If you have any questions, please see the receptionist.

Northeastern Pulmonary Associates, LLC
27 Naek Road, Unit 2, Vernon, CT 06066 Phone: (860) 875-2444 Fax (860) 872-2936

Authorization To Release Protected Health Information

Patient Name: _____ Date of Birth: _____

I authorize (Name of releasing physician) _____
To release from my entire medical record to include (Office notes, Results of diagnostic testing (ie; x-rays, EKG, Laboratory testing), past medical history & correspondence from other providers. Please also include the following:
(Circle): HIV Testing/Treatment Psychiatric Notes Drug/Alcohol Counseling/Testing
Genetic Counseling/Testing & _____

Please mail or fax records to: _____
_____
Protected Health Information to be used for Medical Treatment &/ or: _____

Signature: _____ Date: _____
(Patient or Guardian)
Witness: _____ Date: _____

HIV Related Information: "This information is disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical information is not sufficient for this purpose." Conn. Gen. Stat. 19a-583, 585

Drug and/or Alcohol: I may revoke this authorization at any time, except to the extent that action has been taken thereon. This authorization, unless expressly revoked earlier, **EXPIRES SIX MONTHS FROM THE DATE** or this request. PL9-282 Sec. 52-146

Psychiatric: The confidentiality of a psychiatric record is required under Connecticut General Statutes. This information shall not be transmitted to anyone else without written consent or other authorization as provided by CGS Sec. 52-146.

To The Patient: The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

You have the right to revoke this authorization, at any time, as long as the release has not been completed. PL9=282 Sec. 52-146

This authorization, unless expressly revoked by earlier**, EXPIRES SIX MONTHS FROM THE DATE OF THIS REQUEST.** PL9-282 Sec. 52-146.

Per Northeastern Pulmonary Associates, LLC, HIPAA Policy 0003-The charge for copying of medical records is $0.65 per page plus first-class postage. If special mailing is required, an additional charge of $15.00 will be assessed.

Northeastern Pulmonary Associates, LLC

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Authorization to Share Protected Health Information with an Individual

Patient Name: _____ DOB: _____

Today's Date: _____

I authorize Northeastern Pulmonary Associates, LLC, to release any and all of my medical information to the following person(s):

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

This information being released to the above individual(s) is solely for assistance in my treatment and my healthcare. I understand that this request ***must be*** *completed again in six months' time if I should choose to continue this authorization to release my medical information without an expiration date.*

I understand I have the right to revoke this authorization at any time, as long as the release has not been completed. PL9=282 Sec.52-146

This authorization ***EXPIRES SIX MONTHS FROM THE DATE OF THIS REQUEST****. PL9-282 Sec. 52-146*

Signature: _____ Date: _____
(Patient or Guardian)

Signature: _____ Date: _____
(Witness)

*******Authorization EXPIRES on: _____ (expires in 6 months if expired date not dated)***
(Date)

HIPPA Receipt and consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I _____, understand that as a part of my healthcare, Northeastern Pulmonary Associates, LLC. (NEPA, LLC) originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, 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 and surgical information to my bill*
- *A means by which a third-party payer can verify that services billed were actually provided.*
- *A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.*

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 object to the use of my health information for directory purposes*

~ *The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations/*

I understand that NEPA, LLC reserves all right to change their notice of privacy practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should NEPA, LLC change their notice, they will send a copy of any revised notice to the address I have provided:
I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as a part of this organization's treatment, payment of healthcare Operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I have received a copy of NEPA's HIPPA privacy practices today and I understand and accept / decline the terms of this consent:

Patient Signature: _____
Date Signed: _____

Northeastern Pulmonary Associates
27 Naek Road, Suite 2, Vernon, CT 06066
Phone: (860) 875-2444 Fax: (860) 872-2936

Consent for Medical Treatment

Patient Information:

Patient Name: _____ *Date of birth:* _____
Address: _____
Email: _____

Parents/Guardians Information: (Omit if adult with no guardian)

Name: _____ *Relationship:* _____
Phone: _____
Name: _____ *Relationship:* _____
Phone: _____
Name: _____ *Relationship:* _____
Phone: _____

Adult Emergency Contacts:

Name: _____ *Relationship:* _____
Phone: _____
Name: _____ *Relationship:* _____
Phone: _____
Name: _____ *Relationship:* _____
Phone: _____

I hearby, consent to diagnosis, testing and treatment by Northeastern Pulmonary Associates. My consent will remain in effect until this form is updated. I understand that there are risks associated with any medical treatment and that the Medical Provider will explain these risks to me prior to initiating any testing or treatments. I acknowledge that no guarantees have been made to me concerning the results of this treatment.

By signing below, the patient or parent/guardian acknowledges that they have read and agreed to the terms of this Medical Consent Form.

Patient/Parent/Guardian Signature: _____
Date: _____

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed by SoNE HEALTH Medical Group, PLLC ("SHMG"), and how you can get access to this information. Please review it carefully. This Notice applies to employees, physicians, dentists, volunteers, trainees, and other persons whose conduct is under the direct control of SHMG, whether or not the person is paid by SHMG.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") establishes standards to protect individuals' medical records and other personal health information, granting patients some control over certain parts of their health information and requiring organizations such as SHMG to implement certain safeguards and practices to keep each patient's protected health information (PHI) safe. PHI includes any information created or received by SHMG that relates to the health or condition of an individual, the provision of healthcare to an individual, or payment for the provision of healthcare to an individual, and either identifies the individual or is reasonably believed to provide information that can be used to identify the individual.

SHMG'S PLEDGE REGARDING PHI:
SHMG, in alignment with applicable laws, stands committed to the privacy of each patient's PHI, and SHMG understands and respects the personal and confidential nature of this information. SHMG creates and maintains a record of the care and services provided by SHMG, as well as those records received in support of SHMG care and services, to deliver quality care and to comply with certain legal requirements. This Notice applies to all PHI created, received, or maintained by SHMG, including these records.

Laws Require that SHMG:
- Safeguard the privacy and security of PHI
- Provide individuals with this Notice
- Explain how, when, and why SHMG uses or discloses PHI
- Notify affected patients or their representatives in the event of a breach of unsecured PHI; and
- Follow the terms of this Notice, including not using or disclosing PHI without written permission other than as described in this Notice.

HOW SHMG USES AND DISCLOSES YOUR PHI
The following categories describe different ways SHMG uses and discloses your PHI as permitted or required by federal and state law. Though not an exhaustive list of examples, all the ways SHMG is permitted to use and disclose your PHI fall within one of the categories below.
Treatment: SHMG may use your PHI to treat you and may share your PHI with other healthcare providers, including those outside of SHMG, to coordinate and manage your treatment (this includes psychiatric, HIV-related, certain records that may refer to substance abuse, and most other types of PHI, excluding psychotherapy notes, if necessary for your diagnosis and treatment). For example, a doctor treating you may need to know about a chronic condition or former treatment to provide the best treatment for your current condition.

Payment: SHMG may use and disclose your PHI to bill and collect payment from you, an insurance company, a third party, or a state or federal healthcare program, including disclosure of PHI for the purpose of obtaining a prior authorization. SHMG may disclose PHI to billing and collection agencies to collect payment and to consumer reporting agencies (e.g., credit bureaus). For example, we may need to give your health plan information about visit so your health plan will pay us or reimburse you for the visit.

Healthcare Operations: SHMG may use and disclose your PHI for SHMG's own healthcare operations, including for the purpose of improving the quality, safety, and cost of care, evaluating the skills and performance of people providing care, and providing training programs for students, trainees, and other personnel. For example, we may combine health information about many patients to decide what additional services our practices should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, and other students for quality assurance.

Business Associates: Certain services may be provided on SHMG's behalf by another person or entity (a "business associate") for the purposes of treatment, payment, or healthcare operations, and SHMG may disclose PHI to these business associates for these purposes. SHMG makes such disclosures according to written contracts that outline uses and disclosures of PHI and require business associates to appropriately safeguard information.

Fundraising Activities: SHMG may contact you or disclose limited PHI to the SFHCP Foundation, (the "Foundation") so the Foundation may contact you, in an effort to raise money for SHMG, provided you have not opted out of receiving fundraising solicitations and communications. The Foundation has been delegated the primary responsibility for all fundraising for the benefit of the University of Connecticut, including SHMG. If you wish to opt out of receiving these communications and you wish to direct SHMG to not use or disclose your PHI for fundraising efforts, contact the Foundation, Inc. at 860-200-1858.

Individuals Involved in Your Care: SHMG may disclose to a family member, relative, friend, or other person involved in your care or payment for your care, PHI directly relevant to that person's involvement in your care or payment for your care. SHMG may use or disclose PHI to notify a family member, personal representative, or other person responsible for your care of your location, general condition, or death unless you object or otherwise instruct SHMG. If you are incapacitated or otherwise unable to describe your wishes, SHMG may make such disclosures if SHMG determines such disclosures to be in your best interest. SHMG complies with additional state law confidentiality protections for minors receiving treatment for HIV/AIDS, pregnancy, abortion, venereal disease, substance abuse, or mental health. SHMG discloses PHI to correctional institution or law enforcement officials with custody of an inmate as required for the correctional institution to provide healthcare to the inmate, to protect the health or safety of the public or a person, or for the safety and security of the correctional institution.

Disaster Relief: SHMG may disclose your PHI to an entity assisting in a disaster relief effort to aid in location of you, your friends, or your family members or to provide information about your general condition or death.

De-identified Information or Limited Data Sets: SHMG may use and disclose health information about you after removing any information that potentially identifies you (de-identifying the health information). SHMG may also use and disclose health information about you that constitutes a "Limited Data Set" (as defined by HIPAA), for purposes of public health or healthcare operations, if the recipient of the information signs an agreement to protect the privacy of the information as required by federal and state law. Limited Data Sets do not contain any information that directly identifies you (such as your name, street address, Social Security number, phone number, email address, and other direct identifiers described in the HIPAA definition of a "Limited Data Set").

As Required by Law: SHMG discloses PHI as required by federal or state statute, regulation, or court opinion, including mandatory reporting obligations. Such reporting may include information about suspected abuse, abandonment, neglect, exploitation, domestic violence, workers' compensation program services, and health oversight activities.

Public Safety: SHMG may use and disclose your PHI when believed in good faith to be necessary to prevent a serious and imminent threat to the health or safety of a person or the public.

Public Health Activities: SHMG may disclose your PHI to appropriate government agencies for public health activities for the purpose of preventing or controlling disease, injury, or disability. Such reporting may include births, deaths, suspected communicable disease, suspected overdose events, medication and medical product adverse events, and product recall information.

Lawsuits and Legal Disputes: In the context of any judicial or administrative proceeding, SHMG may disclose your PHI in accordance with applicable law to comply with a court or administrative order, subpoena, discovery request, or other lawful process provided the court has appropriate jurisdiction over SHMG. Notwithstanding the above, in the event SHMG receives and maintains substance use disorder records about you subject to the confidentiality protections of 42 CFR Part 2 ("Part 2 records"), SHMG may not use or disclose such Part 2 records for purposes of civil, criminal, administrative, or legislative proceedings against you without your written consent or an appropriate court order.

Law Enforcement: SHMG may disclose a limited amount of PHI to law enforcement for specific purposes related to identifying or locating a suspect, fugitive, material witness, or missing person, related to a crime, or as required by law.

Coroners, Medical Examiners and Funeral Directors: SHMG may disclose PHI concerning deceased patients to a coroner, medical examiner, or funeral director as necessary to carry out their duties.

Specialized Government Functions: SHMG may disclose PHI as it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability determinations for the United States Armed Forces or Department of State.

Electronic Disclosures & Health Information Exchanges: SHMG makes certain disclosures described within this Notice via electronic transmission, interface, or direct access to our electronic health records system. In addition, SHMG may participate in certain health information exchanges involving disclosure of PHI as permitted by law to other healthcare providers or entities for permitted purposes. As mandated by the State of Connecticut, SHMG participates in Connie, the statewide health information exchange. You may opt-out of Connie by contacting Connie directly as described on their website at www.conniect.org. Additionally, while other states in which a physician operates may not have a mandatory health information exchange, your health information may still be shared with those exchanges where permitted by law.

OTHER USES AND DISCLOSURES OF PHI: SHMG will obtain your authorization to use or disclose your PHI for any reasons not covered by this Notice or applicable law, including certain uses and disclosures related to marketing and the sharing of psychotherapy notes. If you provide authorization to SHMG for a certain use or disclosure of your PHI, you may revoke that authorization, in writing, at any time unless SHMG has already relied on that authorization for a use or disclosure. If you revoke your authorization, SHMG will no longer use or disclose your PHI for the reasons covered by the revoked authorization.

YOUR RIGHTS REGARDING PHI
Right to Access PHI: You have the right to access the PHI about you that SHMG maintains, including the right to inspect or obtain a copy, or both, of the PHI, as well as the right to direct SHMG to transmit a copy to a designated person or entity of your choice. You may be charged a reasonable, cost-based fee for copies of PHI. SHMG may deny a request to access PHI in certain limited circumstances, in which case SHMG will provide the reason for the denial and how to request a review of the denial.

Right to Correct or Update: You have the right to request an amendment or correction of your PHI maintained by SHMG if you feel the information is incomplete or inaccurate. You also have the right to have this request and any decision related to this request included in your record, if you so choose. SHMG requires submission of amendment requests in writing. SHMG reviews all requests and responds in writing within 60 days. If you disagree with SHMG's decision, you have the right to appeal the decision.

Right to an Accounting of Disclosures: You have the right to receive an accounting of certain disclosures of your PHI by SHMG and its business associates. This accounting will not include disclosures for treatment, payment, and healthcare operations, and certain other exceptions. SHMG requires submission of accounting of disclosure requests in writing and requires that the request state a time period no longer than six years prior to the date of the request. SHMG will provide one accounting of disclosures to you each year at no charge but may charge for additional accountings. When you request an accounting of disclosures from SHMG, SHMG may provide you with the accounting of disclosures or the names and contact information of our business associates so that you may contact them directly for an accounting of disclosures made by them.

Right to Request Restriction of Use and Disclosure of PHI: You have the right to request that SHMG restrict the use and disclosure of your PHI maintained by SHMG. SHMG requires submission of restriction requests in writing. While SHMG will try to accommodate such requests, granting of such restrictions is not always possible. However, upon request, SHMG will restrict the information disclosed to your health plan if you have already paid for the service in full prior to the time of service (unless SHMG is legally required to submit the information to the health plan). SHMG may terminate any restriction not legally required by notifying you in writing of the termination; likewise, you may terminate any restriction by notifying SHMG in writing.

Right to Receive Confidential Communications by Alternative Means: You have the right to designate a specific means by which SHMG must communicate with you about confidential matters. For example, you can require that SHMG only contact you at a single address or phone number. SHMG accommodates reasonable requests.

Right to a Copy of This Notice: You may download a copy of the current SHMG Notice of Privacy Practices from SHMG's website at www.sonehealthcare.com or you may obtain a paper copy of the current SHMG Notice of Privacy Practices at any SHMG facility. To submit any written requests related to your rights regarding PHI, please contact the Privacy or Information Security Officer:

SHMG I ATTN: Privacy Officer or Information Security Officer
PO Box 159 I Windsor, CT 06095

860-200-1858 **SoNECompliance@SoNEHEALTH.com**

CHANGES TO THIS NOTICE:
SHMG reserves the right to change this Notice, to change the practices informing this Notice, and to make the revised or changed Notice effective for all PHI maintained as well as any PHI received in the future.

AVAILABILITY OF THIS NOTICE: SHMG conspicuously publishes the current Notice on the SHMG website at www.sonehealthcare.com, posts copies of the current Notice in all SHMG locations where people receive care, and makes available copies of the current Notice throughout SHMG. The effective date of the Notice is indicated at the end of the last page. SHMG requires acknowledgement that you were offered a copy of this Notice as a condition of treatment. Any revisions of this Notice by patients or their representatives, including but not limited to strikeouts, insertions, and deletions, shall not be permitted, and SHMG may refuse to provide treatment under such circumstances.

QUESTIONS AND COMPLAINTS: If you have questions about this Notice, please direct them to your healthcare providers or the SHMG Chief Compliance & Privacy Officer in the Integrity & Compliance Office (contact information below). Additionally, if you believe your privacy rights have been violated or you wish to file a complaint about SHMG's privacy practices, please contact the SHMG Chief Compliance & Privacy Officer in the Integrity & Compliance Office:

SHMG I ATTN: Integrity & Compliance Office
PO Box 159 I Windsor, CT 06095

860-200-1858 **SoNECompliance@SoNEHEALTH.com**

SHMG acknowledges a patient's right to file a complaint regarding SHMG's privacy practices. Patients or their representatives may file a complaint directly with SHMG and/or with other agencies, including but not limited to the United States Department of Health and Human Services (DHHS) Office for Civil Rights (OCR), Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.Q., Room 509F HHH Bldg., Washington, D.C., 20201, email: OCRComplaint@hhs.gov, online: https:// ocrportal.hhs.gov/ocr/smartscreen/main.jsf and https://www.hhs.gov/hipaa/ filing-a-complaint/index.html.

SHMG shall not retaliate against you or your representatives for filing a complaint or grievance with SHMG or any other agency. Additionally, your care will not be affected by the filing of a complaint or grievance with SHMG or any other agency.

SONE HEALTH
Medical Group

EFFECTIVE DATE OF ORIGINAL NOTICE: June 17, 2024
REVISION DATE: N/A