Trinity Medical WNY, PC

FINANCIAL AGREEMENT AND HIPAA CONSENT

AUTHORIZATION FOR PATIENT CARE: The undersigned patient and/or representative ("Undersigned") hereby grants permission to the employees of Trinity Medical, WNY to render routine patient care, and to carry out the orders of the patient's physician, consultants, associates, and assistants of the Undersigned's choice.

ASSIGNMENTS OF BENEFITS: The Undersigned hereby certifies that all insurance information reported to Trinity Medical, WNY and all clinical providers for your care include all available sources of coverage, and assigns to the facilities of Trinity Medical, WNY, sufficient monies from said insurance to pay for the patient's care and treatment. The Undersigned further understands that regardless of assignment of these benefits, the Undersigned is personally responsible for the total charges for services rendered, and further agrees that all amounts are due and payable upon demand. The Undersigned further agrees that Trinity Medical, WNY retain the right to transfer monies from any credit balance account in the Undersigned's name to any other accounts which may be due and payable by the Undersigned

FOR PATIENTS ENTITLED TO MEDICARE AND/OR MEDICAID BENEFITS: If applicable, I hereby irrevocably assign payment of Trinity Medical, WNY services and medical benefits applicable and otherwise payable to me to the designated Trinity Medical, WNY facilities and to all clinical providers providing care to me. I certify that the information provided in applying for payment under Title XVIII or XIX of the Social Security Act, is correct and request that payment of authorized benefits are made to the designated Trinity Medical, WNY facility and all clinical providers providing care on my behalf. The Undersigned authorizes any holder of medical or other information about the patient to release to the Social Security Administration and Centers for Medicare and/or Medicaid Services (CMS) or its intermediaries or carriers, any information needed for this or a related Medicare or Medicaid claim. The Undersigned assigns the benefits payable for physician services to the physician or organization furnishing the services or authorizes such physician or organization to submit a claim to Medicare or Medicaid for payment.

FINANCIAL AGREEMENT: In consideration of the services to be rendered to the patient on this date and all future dates, the Undersigned personally guarantees to pay the account of the designated Trinity Medical, WNY facility/service in accordance with the rates and terms established for the services rendered. The Undersigned also agrees that Trinity Medical, WNY facilities and all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology or by electronic mail, text messaging or by any other form of electronic communication. The undersigned has been informed that many of the physicians at the Trinity Medical, WNY facility are privately practicing independent physicians, NOT Trinity Medical, WNY employees. These physicians (such as x-ray, emergency room, cardiology, etc.) bill separately from Trinity Medical, WNY for their professional services. The undersigned also agrees that if the account remains delinquent and thereby requires the services of a collection agency and/or lawful authorities for collection, the Undersigned shall pay reasonable attorney's fees and collection expenses. The undersigned has been made aware that the Trinity Medical, WNY Healthcare Assistance Program allows persons to receive medically necessary services at no charge or reduced charge, if they are eligible, at Trinity Medical, WNY facilities.

RELEASE OF INFORMATION: The Undersigned hereby permits the Trinity Medical, WNY facilities and agencies, the workforce of such entities, and the members of the Trinity Medical, WNY various medical staff, to disclose the patient's personally identifiable information for purposes related to the patient's treatment, to obtain payment for the patient's treatment, and in the other circumstances listed in the Trinity Medical, WNYs Privacy Notice where federal law does not require my further Authorization. I hereby authorize and consent to release of all PHI; medical and personal information (including but not limited to my home phone, cell phone, work phone, address and email address) to the Trinity Medical, WNY facility and to any and all clinical providers responsible for my care: interpretation of test results; account billing and collection; payment posting and/or processing; or related healthcare functions. The Undersigned also grants permission to release medical information to other health care providers involved in the patient's care and to others involved in planning for the care of the patient. The Undersigned likewise grants permission for these parties to release appropriate medical information back to Trinity Medical, WNY.

USE OF INFORMATION WITHIN Trinity Medical, WNY: I understand that in order for Trinity Medical, WNY to effectively operate and to render appropriate health care, it may be necessary to use and review the patient's medical records and information retained at one or more of the facilities of Trinity Medical, WNY. I therefore authorize the use of the patient's medical information by appropriate personnel and medical staff members within Trinity Medical, WNY for purposes related to the patient's treatment, to obtain payment for the patient's treatment, and for the healthcare operations of Trinity Medical, WNY. Additionally, I understand that Trinity Medical, WNY will include the patient's name, location and general condition in its Patient Directories, such as a patient census.

PATIENT ACKNOWLEDGEMENT FOR COMMUNICATION VIA THE PORTAL CONSENT. The Patient Portal will help you communicate with doctors, nurses and other support staff, allow you to see portions of your health information and in the future access to more types of information and communications. **Do not use the Patient Portal for serious medical problems. For an Emergency please call 911.**

To be completed by the Patient or the Patient's/Client's/Resident's Legal Representative:

I hereby consent to the above and acknowledge that a copy of the Privacy Notice was made available to me.

Name of Patient

Signature of Patient or Legal Representative

Name of Legal Representative (if signed by Legal Representative)

Authority of Legal Representative (e.g., Healthcare Proxy,

(Guardian, Parent) Date Signed: _____/_____/_____

_____Time:_____

CERTIFICATION: The Undersigned certifies that the Undersigned has read this form, and is either the patient, or has legal authority on behalf of the patient to execute the above and accept its terms; and that all information provided is accurate and complete to the best of the Undersigned's knowledge.

Trinity Medical WNY, PC

No Fault Assignment of Benefits Form

New York Motor Vehicle No-Fault Insurance Law

Assignment of Benefits Form

(For accidents occurring on and after 3/1/02)

I,_____("Assignor") hereby assign to Trinity Medical, WNY ("Assignee") all rights
(Print patient's name)
and privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, notwithstanding any other agreement to the contrary.
(Print accident date)

This agreement may be revoked by the Assignee when benefits are not payable based upon the Assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the Assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTIONWITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS, OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

Signature of Patient: _____ Date: _____

Printed Name of Patient: _____ Address: _____

Provider: _____ Signature of Provider: _____

Trinity Medical, WNY

Trinity Medical WNY, PC

Patient Demographic Information

Date of Appointment: _____ Patient Legal Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Ht.: _____ Wt.: _____ SSN: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Race: _____ Primary Language: _____ Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Lives with: ☐ Alone ☐ Spouse ☐ Other (specify): _____

Are you currently working: ☐ Yes ☐ No Full time: ☐ Yes ☐ No Occupation: _____

If not employed, why: ☐ Retired ☐ Disabled, date: _____ ☐ Other (specify): _____ Length of Employment: _____

Employer: _____ Address: _____ Phone: _____

Parent/Guarantor Name: _____ SSN: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Address: _____ Phone: _____

Referring Physician: _____ Address: _____ Phone: _____

Primary Care Physician: _____ Address: _____ Phone: _____

Date of last visit with Primary Care Physician: _____

Pharmacy Name: _____ Address: _____ Phone: _____

Primary Health Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____ Employer: _____

Secondary Health Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____ Employer: _____

Is there another insurance primary to Medicare: ☐ No ☐ Yes If yes, reason: _____

Do you have active Medicaid insurance: ☐ Yes ☐ No Is today's visit related to an automobile or wok injury: ☐ Yes ☐ No

Complete only if related to automobile or work injury: ☐ Work Injury ☐ Automobile Accident Date of Accident: _____

Insurance Carrier Name: _____ Address: _____ Phone: _____

Carrier Claim Number: _____ Adjuster's Name: _____ Ext. (if applicable): _____

If visit is related to a work injury or automobile accident please complete the No Fault/Worker's Compensation Questionnaire and also the Worker's Compensation A-9 form or the No Faults Assignment of Benefits form.

Physician signature _____ Date: _____

Trinity Medical WNY, PC

Patient Medical History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Why are you seeing the provider today:

Shoulder: ☐ Right ☐ Left Elbow: ☐ Right ☐ Left Wrist: ☐ Right ☐ Left Hand: ☐ Right ☐ Left

Hip: ☐ Right ☐ Left Knee: ☐ Right ☐ Left Ankle: ☐ Right ☐ Left Foot: ☐ Right ☐ Left

Other (please specify): _____

Injury is related to: ☐ Work injury; date _____ ☐ Automobile accident; date _____ ☐ Sports injury; date _____

☐ Other (please specify): _____ Onset was: ☐ Sudden ☐ Gradual Duration: _____

In your own words, please describe your chief complaint: _____

_____

What, if anything, alleviates your condition: _____

Have you:

☐ Yes ☐ No Had any diagnostic studies, other than routine X-Rays taken? Yes, where: _____

☐ Yes ☐ No Seen any other doctors for this condition? Yes, who, Specialty: _____

☐ Yes ☐ No Had any formal physical therapy for this condition? Yes, where: _____

☐ Yes ☐ No Had any previous surgery for this condition? Yes, name of procedure, when: _____

☐ Yes ☐ No Missed work for this condition? Yes, dates: _____

Allergies: ☐ None ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Latex ☐ Pollen ☐ Iodine ☐ Nickel ☐ Cobalt ☐ Chromate

Other (specify): _____ Reaction: _____

Medications: Please list all current medications, including over the counter medications, such as vitamins. Attach additional sheets if necessary.

Drug	Strength	Dose (how often)

Surgeries: Please list all prior inpatient or outpatient procedures. Attach additional sheets if necessary. ☐ None

Anesthesia complications: ☐ No ☐ Yes Explain: _____

Surgery	Date	Surgery	Date

Are you currently using any assistive devices for ambulation? ☐ No ☐ Yes Explain: _____

Physician signature _____ Date: _____

Trinity Medical WNY, PC

Patient Medical History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Please check conditions you currently have, or have had in the past:

☐ AIDS	☐ Eating Disorder: _____	☐ Miscarriage	☐ Respiratory Disease
☐ Anemia	☐ Gout	☐ Mononucleosis	☐ Rheumatoid Arthritis
☐ Arthritis	☐ Hepatitis A, B, or C (circle one)	☐ Multiple Sclerosis	☐ Sleep Apnea
☐ Asthma	☐ Hernia	☐ Mumps	☐ Scarlett Fever
☐ Bleeding Disorder	☐ HIV Positive	☐ Osteoporosis	☐ Thyroid Disease
☐ Cancer: _____	☐ Kidney Disease	☐ Pacemaker/Defibrillator	☐ Tuberculosis
☐ Cardiovascular Disease	☐ Liver Disease	☐ Psychiatric Condition	☐ Typhoid Fever
☐ Chemical Dependency	☐ Measles	☐ Pneumonia	☐ Ulcers
☐ Chicken Pox	☐ Migraine headache	☐ Polio	☐ Venereal Disease
☐ Diabetes (Insulin Dependent)	☐ Other (please specify) _____		
☐ Diabetes (Non-Insulin Dependent)	_____		

Please check any symptoms you are currently experiencing:

Constitutional	Cardiovascular	Gastrointestinal	Skin	Neurologic
☐ Chills	☐ Blood clots	☐ Abdominal pain	☐ Bruising	☐ Confusion
☐ Fainting	☐ Edema	☐ Change in appetite	☐ Lesions	☐ Depression
☐ Impaired growth	☐ Coldness in extremities	☐ Constipation	☐ Ulcers	☐ Vertigo
☐ Change in height	☐ Faintness/dizziness	☐ Diarrhea	☐ Warts	☐ Numbness
☐ Change in weight	☐ Chest pain	☐ Excessive vomiting	☐ Brittle nails	☐ Tingling
☐ Shakiness	☐ Other: _____	☐ Other: _____	☐ Thickened nails	☐ Other: _____
☐ Other: _____			☐ Other: _____	

Musculoskeletal				
☐ Fibromyalgia	☐ Difficulty ambulating	☐ Instability	☐ Muscle cramps	☐ Muscle weakness
☐ Joint pain	☐ Muscle stiffness	☐ Leg swelling	☐ Movement limitations	☐ Tremors

☐ Other: _____

Personal Habits:

Do you currently smoke: ☐ No ☐ Yes Former smoker: ☐ No ☐ Yes Type and amount: _____

Do you currently use alcohol: ☐ No ☐ Yes Type and amount: _____

Do you currently use drugs: ☐ No ☐ Yes Type and amount: _____

Do you currently follow any special diet: ☐ No ☐ Yes Explain: _____

Do you currently exercise: ☐ No ☐ Yes Type and frequency: _____

List highest grade completed or degree received: _____

Physician signature _____ Date: _____

Trinity Medical WNY, PC

Patient Medical History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Family History: List all major medical illness for each member.

Mother: _____

Father: _____

Grandparents: _____

Siblings: _____

Children: _____

The information on this form is accurate to the best of my knowledge. I understand this Practice does not participate in the New York State Medicaid program, and, failure to disclose my coverage with the Medicaid program, prior to receiving services, may result in a balance being owed by me. I understand it is my responsibility to notify the office of any changes in the information contained on this form. I hereby give my consent to Trinity Medical, WNY to use and disclose protected health information about me to carry out treatment, payment, and health care operations. I authorize payment of medical benefits to the named physician/practice for services rendered. I understand that I am responsible for any additional fees incurred as a result of placing my account with an outside collection agency.

x _____ Date: _____

Signature of Patient or Parent/Legal Guardian (if patient under 18 years of age)

x _____

Printed Name of person signing form if different from patient

Physician signature _____ Date: _____

Trinity Medical WNY, PC

Payment Policies

We would like to thank you for choosing Trinity Medical, WNY as your healthcare provider. We are committed to providing you with the best possible medical care and make every effort to keep down the cost of this medical care. The following information outlines your financial responsibilities related to payment for your care.

Accepted Insurance plans: Please contact your practice directly for accepted Insurance plans

Copays/Deductible/Co-Insurance:

We are contractually obligated to report visits to an individual's insurance provider. When the insurance processes these bills, they charge all out of pocket expenses (copay, deductible, and co-insurance) based on the individuals policy contract which we are obligated to collect. We will collect these payments due at time of service. For your convenience we accept Visa, MasterCard, Discover, personal checks and cash. If you do not have your payment at time of service, your appointment may be rescheduled.

Patient Balances:

Any patient balance that remains unpaid after ninety (90) days may be transferred to a collection agency and/or attorney to possibly pursue legal action. You agree to be responsible for amounts owed to our practice as well as any fees assessed by the collection agency and/or attorney costs for legal proceedings. These collection agency and/or attorney fees will be added to any unpaid delinquent balance. Payment plans are available and can be arranged.

Other Administrative Fees:

No-Show/Cancellation less than 24 hours – Missing an appointment or failure to cancel within 24 hours prior to your appointment will result in a $25 fee.

Disability Forms – There will be a $10.00 administrative fee for disability form completion.

I have read, understand and agree to the above financial policy of Trinity Medical, WNY regarding payment for my medical care.

Printed Name _____

Signature _____

Date _____ Account # _____

Trinity Medical WNY, PC

Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. OUR POLICY REGARDING YOUR HEALTH INFORMATION

We are committed to preserving the privacy and confidentiality of your health information. This Privacy Notice describes how Trinity Medical WNY, PC ("Trinity Medical") may use and disclose your protected health information according to applicable laws and regulations. It also describes your rights with respect to your protected health information. Your "protected health information" includes most information about your physical and mental health, such as symptoms, treatment, test results, and demographic data, which contains details that can be used to identify you, We are required by law to maintain the privacy of your "protected health information" and to provide you with this notice of your legal duties and privacy practices. Trinity Medical's many components will comply with this Notice, including Trinity Medical's hospitals, primary care, long term care, home care, ambulatory care, laboratories, chemical and physical rehabilitation, foundations and workforce members, including volunteers. Additionally, all health care providers who provide services for Trinity Medical and within Trinity Medical's facilities will comply with this Notice and will share your protected health information for treatment, payment and healthcare operations (as defined herein.)

We reserve the right to change this notice and to make the revised notice effective for all protected health information that we maintain at that time and any information we may receive in the future. We will post a copy of the current notice in our facilities and we will make any revised notice available at the facilities for you to request a copy. We are required to abide by the terms of this notice while it remains in effect, as required or authorized by law.

B. USES AND DISCLOSURES WITH AND WITHOUT YOUR AUTHORIZATION

We must obtain your written permission or "authorization" to use or disclose your protected health information except in the limited situations listed below, which do not require your written authorization:

1. **Treatment.** We will use and disclose your protected health information to provide, coordinate and manage your health care and related services. We may disclose your protected health information to health care providers, including providers not affiliated with Trinity Medical, so that they may provide you with treatment. For example, we may disclose your protected health information to a pharmacy to fill a prescription, to a laboratory to order a test, or a specialist for consultation.

2. **Payment.** We will use and disclose your protected health information, as needed, for Trinity Medical to obtain payment for our health care services. For example, we may disclose protected health information to your health insurance company so we may obtain prior approval for a surgery, to determine whether you are eligible for benefits or to determine whether a particular service is covered under you plan. We may disclose your protected health information to other health care providers, health plans, and health care clearinghouses for their payment activities. For example, we may disclose protected health information to anesthesia care providers so that they may obtain payment for their services.

3. **Health Care Operations:** We will use and disclose your protected health information for our health care operations. For example, we may use your protected health information to evaluate the performance of Trinity Medical's personnel and to perform licensing, training, and accreditation activities. In certain situations, we may also disclose your protected health information to another health care provider, health plan, or health care clearinghouse who has or had a relationship with you, for the purpose of that entity's health care operations, as long as the protected health information is related to your relationship with that entity. For example, Trinity Medical may disclose your protected health information to allow another entity to conduct activities to determine whether they have provided quality services, to review the performance and qualifications of health care providers, to conduct training programs, and to perform accreditation, certification, licensing or credentialing activities.

4. **Law Enforcement Purposes.** We may disclose your protected health information to law enforcement officials under certain circumstances when we are required or permitted by law to disclose such information. For example, we may disclose your protected health information if we are required by law to report a certain type of wound or injury, such as a gun-shot wound. We may also disclose your protected health information pursuant to an order, warrant, subpoena or summons issued by a judicial officer. Under certain circumstances, we may disclose your protected health information pursuant to administrative requests related to law enforcement purposes. We may disclose limited protected health information to law enforcement officials upon their request to assist them in identifying or locating a suspect, fugitive, material witness or missing person.

   Additionally, under certain circumstances we may disclose your protected health information to law enforcement official's request about a victim of a crime or in order to report evidence of criminal conduct that occurred on our premises.

5. **Public Health Activities.** Trinity Medical may disclose your protected health information to certain public health authorities and others according to specific rules that apply to public health activities. For example, Trinity Medical may disclose your protected health information to public health authorities or other government authorities authorized by law to receive such information for purposes of preventing or controlling disease, injury, disability, or child abuse or neglect or for the conduct of public health surveillance, investigations and interventions. We may also disclose your protected health information to certain individuals subject to the jurisdiction of the Food and Drug Administration FDA-regulated products or activities, to certain individuals who may be at risk of contracting or spreading a disease or condition, and under certain circumstances to your employer if we have provided health care to you at your employer's request.

6. **Health Oversight Activities.** Trinity Medical may disclose your protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations, proceedings and actions; inspections; licensure or disciplinary actions; and other activities necessary for appropriate oversight of the health care system and oversight of certain programs and entities as authorized by law.

7. **Judicial and Administrative Proceedings.** We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena, discovery request or other lawful process to the extent authorized by state law if we receive satisfactory assurances from the party requesting your information that you have been notified of the request or that they have made reasonable efforts to obtain a qualified protective order. A qualified protected order is an order of a court or tribunal that prohibits the use or disclosure of your protected health information for any purpose other than the proceeding for which it was requested and which requires that your protected health information will be returned to Trinity Medical at the end of the proceeding.

8. **Specialized Government Functions.** In certain circumstances, federal regulations authorize Trinity Medical to use and/or disclose your protected health information for specialized government functions. If you are a member of the armed forces, Trinity Medical may use and disclose your protected health information as directed by appropriate military authorities. We may disclose your protected health information to authorized federal officials for certain national security and intelligence activities and to protect the President of the United States and other dignitaries. Trinity Medical may also disclose your protected health information to law enforcement personnel or to a correctional institution if such information is required for the health and safety of inmates, law enforcement personnel, individuals at the correctional institution, or individuals responsible for transporting inmates or if such information is required to maintain safety, law and order at a correctional institution.

9. **Suspected Abuse, Neglect or Domestic Violence.** Trinity Medical will disclose medical information that reveals that you may be a victim of abuse, neglect or domestic violence to a government authority if Trinity

Medical is required by law to make such disclosure. For example, state law requires health care professionals to report cases of suspected, child abuse or maltreatment. If Trinity Medical is authorized, but not required, by law to disclose evidence of suspected abuse, neglect or domestic violence, it will do so if it believes that the disclosure is necessary to prevent serious harm, or if you are incapacitated and government officials need such information for an immediate law enforcement activity.

10. **To Avert Serious Threat to Health or Safety.** Trinity Medical may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is made to an individual who is reasonably able to prevent or lessen the threat.

11. **Research.** We may use and disclose your protected health information for research as long as such research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to preserve the privacy of your protected health information. For example, a research project may involve comparing the health of patients who received one treatment to those who received another treatment for the same condition. Before we use or disclose protected health information for research purposes, the research project will go through a special review and approval process. Even without special approval, however, we may permit researchers to review your protected health information if it is necessary to help them prepare for a research project, as long as they do not remove or take a copy of any protected health information.

12. **Medical Examiners, Funeral Directors, and Organ Donation.** Trinity Medical may disclose your protected health information to a medical examiner for identification purposes, to determine the cause of death or for other purposes authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, to permit the funeral director to carry out his or her duties. Additional, Trinity Medical may use and disclose your protected health information for the purpose of arranging for cadaveric organ, eye, or tissue donation and transplantation.

13. **Worker's Compensation.** The facility may disclose your protected health information, as authorized by and in compliance with worker's compensation laws.

14. **Appointment Reminders.** Trinity Medical may, from time to time, use or disclose your protected health information to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that we believe may be of interest to you. Trinity Medical may remind you of appointments by mailing a postcard to you at the address provided by you or by telephoning your home and leaving a message on your answering machine or with the individual answering the phone. Trinity Medical will not disclose any information with these appointment reminders except your name, your address and the time, date and location of your appointment.

15. **Fundraising.** Trinity Medical may use limited protected health information for fundraising purposes and may disclose such information to its Business Associates and to institutionally related foundations for assistance in raising funds for Trinity Medical. Trinity Medical may contact you for the purpose of raising money for Trinity Medical, but you have the right to opt out of receiving fundraising communications. Any fundraising communication sent will contain information on how recipients may opt out of future communication of this type.

16. **De-identified Information.** Trinity Medical may de-identify your protected health information according to specific federal rules so that the information does not identify you and cannot be used to identify you. Trinity Medical may use and disclose your de-identified information. Trinity Medical may also partly de-identify your protected health information by removing your name, address, telephone number and many other identifying factors to create a "limited data set", which may be used and disclosed for research purposes. Your protected health information will only be disclosed in the form of a "limited data set" to recipients who

sign an agreement to use your protected health information for specific purposes according to law and who agree not to identify you.

17. **Patient Directory.** Unless you object, Trinity Medical may use your name, location, general condition and religious affiliation to maintain Trinity Medical's patient directory and may disclose such information to members of the clergy and (except for religious affiliation) to individuals who ask for you by name.

18. **Business Associates.** Trinity Medical may disclose your protected health information to a business associate of Trinity Medical if we obtain satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your protected health information. A "business associate" is an entity that provides certain services to Trinity Medical or assists Trinity Medical in undertaking some functions, such as a billing company that assists Trinity Medical in submitting claims for payment to insurance companies. Security provisions that legally apply to Trinity Medical are also applied to our business associates.

19. **Personal Representatives.** Trinity Medical may disclose your protected health information to or according to the direction of a person who, under applicable law, has the authority to represent you in making decisions related to your health. For example, we may disclose your protected health information to an agent who you authorized through a health care proxy form to make health care decisions for you in the event that you should become unable to make your own health care decisions.

20. **Family and Friends:** Under certain circumstances, Trinity Medical may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your protected health information directly relevant to such person's involvement with your care or the payment for your care. Trinity Medical may also use or disclose your protected health information to the previously named individuals as well as to a public or private entity authorized by law or by its charter to assist in disaster relief efforts to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, the following conditions will apply:

    a. If you are present at or available prior to the use or disclosure of your protected health information, Trinity Medical may use or disclose your protected health information if you agree, or if Trinity Medical can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

    b. If you are not present or are unable to agree or object to the use of disclosure because of incapacity or an emergency, Trinity Medical will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the protected health information that is directly relevant to the person's involvement with your care.

21. **Required by Law.** In addition to those uses and disclosures listed above, we may use and disclose your protected health information if and to the extent we are required by law.

C. YOUR RIGHTS: You have the following rights regarding your protected health information:

1. **Right to Revoke an Authorization.** You may revoke an Authorization in writing, at any time. To request a revocation, you must submit a written request to Trinity Medical's Privacy Officer, whose contact information is listed below.

2. **Right to Request Restrictions on Uses and/or Disclosures.** You may request restrictions on the use and/or disclosure of your protected health information for treatment, payment or health care operations. To request restrictions, you must submit a written request to Trinity Medical's Privacy Officer. In your written request, you must identify the specific restriction requested. Except in limited circumstances, Trinity Medical is not obligated to agree to any of your requested restrictions. If Trinity Medical agrees to your requested restriction,

we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide you with emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction.

Requests submitted in writing for restriction of disclosure to a health plan for purposes of carrying out payment or healthcare operations will be honored provided the information pertains solely to a health care items or service paid for out-of-pocket by the individual unless prohibiting such disclosure is restricted by law.

3. **Right to Request Confidential Communications.** You may request to receive confidential communications of protected health information by alternative means or at alternative locations. You must make your request to Trinity Medical's Privacy Officer. Trinity Medical will accommodate all reasonable requests. We may condition this accommodation on your providing us with information as to how payment will be handled or by specifying an alternative address or other method of contact. We will not require you to provide an explanation for your request.

4. **Right to Inspect and Copy Information.** According to federal regulations, you may generally inspect and obtain a copy of your protected health information that we maintain in a designated record set. A "designated record set" is a group of records that include medical and billing records or other records that Trinity Medical uses for making decisions about you. Under federal regulations, however, you have no right to inspect or copy certain records, including psychotherapy notes, information complied in reasonable anticipation of litigation. Please note that New York State's Mental Hygiene Laws and Public Health Law may provide you with independent rights to inspect and copy such information. If federal law does not allow you to inspect or copy certain information, such as psychotherapy notes, but State law allows you to inspect and copy such information, Trinity Medical will respond to your request to access such information in accordance with New York State law. We may deny your request to inspect or copy your protected health information. Depending on the circumstances, you may or may not have a right to appeal our decision to deny your request. To inspect or copy your protected health information, you must submit a written request to the Health Information Management Department or Long Term Care Facility Administration. If you request a copy of your information, we may charge you a fee for the cost of copying and mailing your information and for other costs only as allowed by law.

   If your protected health information is maintained in an EHR (Electronic Health Record) upon your written request, providing no other restrictions apply, you may obtain an electronic copy of such information and request that such a copy be transmitted directly to an entity or person designated by you. A fee may be charged for this service as allowed by law.

5. **Right to Amend your Information.** You may request that we amend your protected health information that we maintain in a designated record set. To request an amendment, you must submit a written request, along with a reason that supports your request to our Privacy Officer. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us. If you file such a statement, we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

6. **Right to Receive an Accounting.** You may request an accounting of certain disclosures of your protected health information made by Trinity Medical after April 14, 2003. We are not required to account for some disclosures, including those made for treatment, payment or health care operations. Additionally, we are not required to provide you with an accounting of disclosures that you authorize or with an accounting of some disclosures that we are permitted to make without your authorization. Your request for an accounting of disclosures must be submitted in writing to our Privacy Officer and must specify a time period to be covered by the accounting. You right to receive this information is subject to additional exceptions, restrictions and limitations.

7. **Right to Receive a Copy of Notice.** Upon your request, we will provide you with a paper copy of this Privacy Notice.

8. **Right to Notification of an Unauthorized Unsecured Breach.** In the case of a breach of unsecured protected health information, you or your next of kin (if individual is deceased) will be notified by mail or e-mail if the later is specified as preferred by you.

9. **Right to Complain.** You have the right to complain to Trinity Medical or to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. You may complain to Trinity Medical by contacting Trinity Medical's Privacy Officer, using the contact information below. You will not be retaliated against in any way for filing a complaint.

10. **Right to Receive Lab Reports.** Upon your request or your personal representative's request, the laboratory may provide you or your personal representative, and those persons specified under 45 CFR 164.524(c)(3)(ii), as applicable, with access to completed test reports that, using the laboratory's authentication process, can be identified as belonging to you.

D. **PRIVACY CONTACT**: Trinity Medical's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Questions regarding matters covered by this Notice shall be directed to the Privacy Officer. You may contact the privacy Officer at:

Kimberly E Whistler, Esq.
Compliance & Privacy Officer
Administrative & Regional Training Center
144 Genesee St, 6th Floor
Buffalo, New York, 14203