Patient Information Sheet

Patient_____ Physician_____

Personal Information

Birthdate _____ Age _____ Social Security # _____

Home Address _____

Street/City/State/Zip _____

Phone _____ Email _____ Sex _____

Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed

Spouse's Name _____

Emergency Contact _____ Relation _____

Phone _____

Employment Information

Student: Full-time _____ Part-time _____ If so, where _____

Employed: Full-time _____ Part-time _____

Employer _____Occupation _____

Address _____ Work Phone _____

Spouse's Employment Information

(Only if policy holder is spouse)

Spouse's Employer _____ Occupation _____

Address _____ Work Phone _____

Primary Insurance Coverage

Insurance Company _____ Group # _____

Policy Holder _____ Birthdate _____ Policy or ID# _____

Effective Date _____Relationship of Patient to Policy Holder _____

Secondary Insurance Coverage

Insurance Company _____ Group # _____

Policy Holder _____ Birthdate _____Policy or ID# _____

Effective Date _____ Relationship of Patient to Policy Holder _____

EXOS Physical Therapy & Sports Medicine
Medical History

Name: _____ Date :_____

Date of Last Physical: _____ Age:_____ DOB: _____

Please fill out the following health information honestly and thoroughly, to the best of your knowledge. Do you now, or have you in the past, had any of the following (please also consider during and/or after exercise):

Anemia	☐Yes ☐ No	Hypoglycemia	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	Kidney/Bladder Infections	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Kidney Stones	☐ Yes ☐ No
Anorexia/Bulimia	☐ Yes ☐ No	Kidney Disease/Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Liver Disease/Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Menstrual Irregularities	☐ Yes ☐ No
Blood Disorder	☐ Yes ☐ No	Metal Implants	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Migraines	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No
Chest Pain/Angina	☐ Yes ☐ No	Muscle/Joint Injury	☐ Yes ☐ No
Cholesterol Elevation	☐ Yes ☐ No	Nausea/Vomiting	☐ Yes ☐ No
Chronic Bronchitis	☐ Yes ☐ No	Neurological Disorders	☐ Yes ☐ No
Bowel/Bladder Dysfunction	☐ Yes ☐ No	Numbness/Tingling	☐ Yes ☐ No
Concussion	☐ Yes ☐ No	Osteoarthritis	☐ Yes ☐ No
Deafness/Hearing Problem	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Prostate Trouble	☐ Yes ☐ No
Digestive Problems	☐ Yes ☐ No	Phlebitis	☐ Yes ☐ No
Dizziness/Fainting	☐ Yes ☐ No	Respiratory Issues	☐ Yes ☐ No
Epilepsy/Seizures	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Fatigue	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Fractures	☐ Yes ☐ No	Ringing in your Ears	☐ Yes ☐ No
Headache	☐Yes ☐ No	Sickle Cell	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Skin Disease/Abnormalities	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Smoking	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Heart Palpitations	☐ Yes ☐ No	Surgeries	☐ Yes ☐ No
Heart Related Illness	☐ Yes ☐ No	Thyroid conditions	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Hernia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Vision Problems	☐ Yes ☐ No

Please list any other health issues that have affected you in the past, or are currently affecting you, that were not listed above:

_____

_____

Have you gained OR lost a significant amount of weight in the last year? ☐ Yes ☐ No
If YES, please explain:

_____

_____

During the past month have you been feeling down, depressed, or hopeless? ☐ Yes ☐ No
During the past month have you been bothered by having little interest or pleasure doing things? ☐ Yes ☐ No
Have you been diagnosed with any cardiac-related problems? ☐ Yes ☐ No

Have you had an injury before? ☐ Yes ☐ No
Have you ever had surgery? ☐ Yes ☐ No
If YES to either of the above, please describe below:

_____

_____

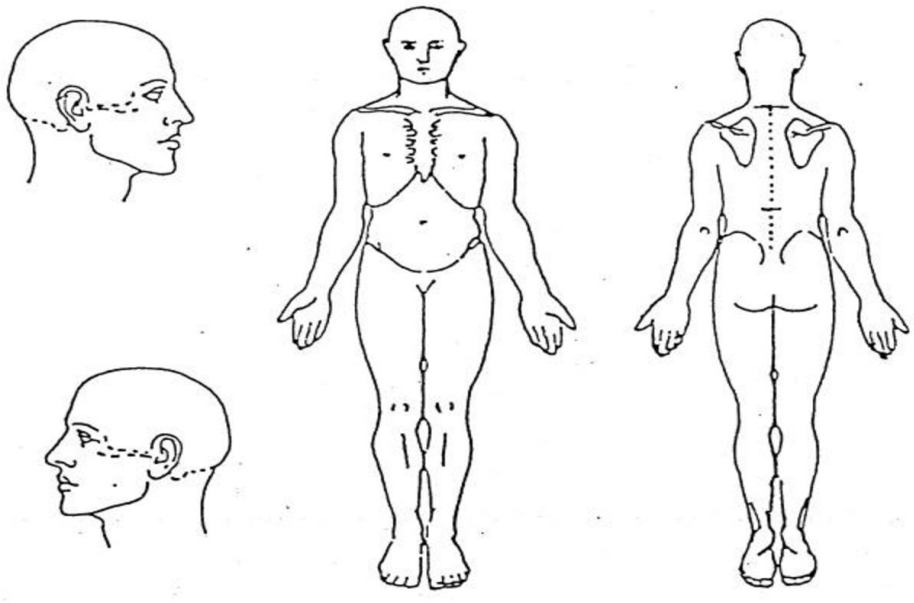
_____

Do you have any allergies (including but not limited to medications, supplements, food, stings/insect bites, etc.) ☐ Yes ☐ No
If YES, please explain:

_____

_____

Please fill in the diagram below for the condition(s) of which you are being treated in therapy:
xxx- stabbing ooo- numbness/tingling +++- pain sss - aching



Medications

Please list any medications (prescribed, over the counter, vitamins, etc) you are currently taking with dosage and frequency.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(Please use the space below if additional space is needed)

The statements above are true and complete to the best of my knowledge.

Name (print) _____

Signature _____ Date: _____

EXOS Physical Therapy & Sports Medicine
Insurance Verification

Patient Name: _____ Date: _____

Policy Holder Name: _____

Insurance Company/Type: _____

In Network: ☐Yes ☐ No Out of Network: ☐Yes ☐ No

Reference Number: _____

Certification Number: _____

Certification Details: _____

Deductible Amount: _____ Amount Met: _____

Out of Pocket Max: _____ Amount Met: _____

Copay per visit: ☐Yes ☐ No Amount: _____

Co-Insurance per visit: ☐Yes ☐ No Amount: _____

Number of visits per year: _____ Number Remaining: _____

Therapy Max: _____

The information above has been recorded based on the benefits and eligibility supplied to us by your insurance carrier and is not a guarantee of payment or benefits. Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance. It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when services are rendered. We require that arrangement for payment of your estimated share be made today. If payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to EXOS Physical Therapy and Sports Medicine. The above does not apply for those patients considered Worker's Compensation; however, as a Compensation patient you may be held responsible for your charges in the event your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by EXOS Physical Therapy and Sports Medicine, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

If further therapy is required beyond the above authorization period, I will follow-up to make sure that any additional authorization has been obtained from the insurance carrier prior to any additional treatment, if this is required by my insurance company. If I incur rehabilitation without appropriate authorization from my carrier, I will be responsible for the charges in full as well as any non-covered services. I will also be liable for all treatment that exceeds what is allowed by my insurance plan. It is my responsibility to ensure this information remains valid throughout my treatment.

Signature of Patient or Responsible Party: _____
Date: _____

INFORMED CONSENT FOR PHYSICAL THERAPY TREATMENT

As you have consulted with EXOS Physical Therapy and Sports Medicine ("EXOS") and have decided to receive physical therapy services from EXOS, **IT IS IMPORTANT THAT YOU, THE PATIENT, READ THIS CONSENT FORM CAREFULLY AND OBTAIN ANSWERS TO ANY QUESTIONS THAT YOU MAY HAVE.**

Physical Therapy: Physical therapy involves the use of several modalities of evaluation and treatment. Accordingly, at EXOS we use a variety of procedures and treatments to help us to try and improve your physical function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

As patient responses to a specific form of treatment can vary widely from patient to patient, it is not always possible to predict responses to a specific form of treatment. Therefore, EXOS cannot guarantee any reaction or success to a given form of treatment. There is also a risk that your treatment may result in pain, injury, or may aggravate a previous condition.

You have the right to inquire as to the form of treatment based upon your history, diagnosis, symptoms, and testing result. You may also discuss with your physical therapist the potential risks and benefits of a specific treatment and possible alternative treatments. You have the right to decline any portion of treatment at any time or during your treatment sessions. Your physical therapist stands ready to answer any questions you may have regarding a given course of treatment, type of exercise, associated risks, and possible alternatives. This Consent Form is based upon your informed decision to participate in the proposed treatment plan for physical therapy services as explained to you by the Physical Therapist identified below.

Consent for Care:

_____

Name of Patient/ Authorized Legal Guardian (if applicable)

_____

Diagnosis/Condition

Date of Evaluation (MM/DD/YY): _____

I hereby authorize and consent for EXOS, including _____ (Physical Therapist) and/or any physical, assistant or students in training under the direction of the Physical Therapist as selected by him/her, to provide physical therapy services in accordance with the proposed treatment plan which has been explained to me in a way that I can understand. I understand that some of the physical therapy services provided to me at EXOS may be performed by a physical therapist other than the Physical Therapist as identified in this Consent Form.

The above Physical Therapist has discussed with me in words that I can understand, my diagnosis, conditions, the reasons for and benefits of the proposed plan of physical therapy services, the reasonable likelihood of its success, the possible consequences of not choosing this plan, the possible risks associated with this plan, and possible alternatives and risk associated with those alternatives, as well as my goals of recovery and any potential problems that might arise during treatment. I understand and have discussed with the above Physical Therapist that my condition could also be treated by alternative procedures or therapies, but I have decided not to undergo these alternative treatments at this time. I understand that there are risks associated with physical therapy which may include the aggravation of previous injuries or the worsening of current conditions, as well as injuries common to the performance of exercise.

I understand that I am giving this consent with the understanding that any treatment/procedure involves some risks and hazards, and that no guarantees have been made to me as to any treatments or examinations by EXOS or the Physical Therapist and supporting staff. The approximate duration of my treatment has been discussed with me by the Physical Therapist indicated above.

PHYSICAL THERAPIST DECLARTION:

Prior to presenting this Consent Form, I have discussed with the Patient and/or the Patient's Guardian (if applicable) the planned examination/assessment; evaluation, diagnosis, and prognosis/plan; the intervention/treatment to be provided; the nature of the proposed treatment; the benefits reasonably expected from the proposed treatment, together with the material risks and dangers of the proposed treatment; treatment alternatives, as well as the risks and benefits of such alternatives; and that EXOS cannot provide any form of guarantee. I have explained the contents of this Consent Form to the Patient and/or the Patient's Guardian (if applicable) and have answered all of the Patient's and/or the Patient's Guardian's (if applicable) questions in a language the Patient and/or the Patient's Guardian (if applicable) understands and all questions have been answered in a satisfactory manner. To the best of my knowledge, the Patient and/or the Patient's Guardian (if applicable) has and/or have been adequately informed and has and/or have consented to this treatment/plan of care.

_____ Date: _____

Physical Therapist Signature (MM/DD/YY)

PATIENT CONSENT:

I HEREBY CERTIFY THAT I HAVE READ THIS FORM (OR HAVE HAD IT READ TO ME) AND FULLY UNDERSTAND THE ABOVE CONSENT. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I DO NOT DESIRE ANY FURTHER EXPLANATION AND UNDERSTAND AND ACKNOWLEDGE THAT COMPLICATIONS CAN RESULT.

I CERTIFY THAT I HAVE HAD SATISFACTORY OPPORTUNITY TO DISCUSS MY CONDITION, DIAGNOSIS, AND TREATMENT WITH THE ABOVE PHYSICAL THERAPIST WHO HAS FULLY EXPLAINED THE NATURE AND EXPECTED BENEFITS, ALTERNATIVES AND RISKS INVOLVED IN THE PROPOSED PLAN FOR PHYSICAL THERAPY SERVICES I HAVE CHOSEN AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I HAVE BEEN GIVEN ENOUGH INFORMATION AND FACTS UPON WHICH TO MAKE AN INFORMED DECISION ABOUT CHOOSING THE PROPOSED PLAN FOR PHYSICAL THERAPY SERVICES, THE ALTERNATIVES, AND RISKS IN MY OWN LANGUAGE AND IN A MANNER THAT I CAN UNDERSTAND. I ACCEPT THAT NO GUARANTEES HAVE BEEN MADE TO ME CONCERNING THE PROPOSED PLAN FOR PHYSICAL THERAPY SERVICES. I UNDERSTAND THAT THE PROPOSED PLAN FOR PHYSICAL THERAPY SERVICES MAY NOT IMPROVE MY CONDITION AND MAY, IN FACT, WORSEN IT.

I CERTIFY THAT I HAVE DISCLOSED COMPLETELY AND TRUTHFULLY ALL OF MY MEDICAL HISOTRY; MY COMPLAINTS AND/OR AILMENTS; AND MY USE OF ALL PRESCRIPTION AND NON-PRESCRIPTION DRUGS, VITAMINS, MINERALS, AND DIETARY SUPPLEMENTS.

I HAVE CAREFULLY READ AND FULLY UNDERSTAND THIS CONSENT FORM AND I VOLUNTARILY AUTHORIZE AND CONSENT TO THE PROPOSED PLAN FOR PHYSICAL THERAPY SERVICES.

DO NOT SIGN THE BELOW UNLESS YOU HAVE READ AND THOROUGLY UNDERSTAND THIS CONSENT FORM:

_____

Name of Patient (Print or Type)

_____ _____

Signature of Patient Date (mm/dd/yyyy)

_____ _____

Name of Legal Guardian (Print or Type)
(Required if Patient is a minor or an adult who is unable to sign the form)

Relation to Patient

_____ _____

Signature of Legal Guardian
(Required if Patient is a minor or an adult who is unable to sign the form)

Date (mm/dd/yyyy)

Using the Patient's primary language, _____, the interpreter acknowledges the patient understands and agrees with the above statement.

_____

Interpreter's Printed name

_____ _____

Interpreter's Signature **Date (mm/dd/yyyy)**

EXOS NOTICE OF PRIVACY PRACTICES

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.

OUR RESPONSIBILITIES

This Notice of Privacy Practices ("Notice") describes the privacy practices of EXOS AP Arizona, LLC; EXOS AP San Diego, LLC; Athletes' Performance Florida, LLC; EXOS AP Los Angeles, LLC; EXOS AP Texas, LLC; EXOS Physical Therapy Management Services, LLC; and EXOS Physical Therapy and Sports Medicine, LLC who are members of an Affiliated Covered Entity (the "EXOS ACE")(collectively referred herein as "We", "Our", or "Us"). Affiliated Covered Entities consist of groups of Covered Entities under common ownership or control and who are permitted to designate themselves as a single Covered Entity for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The members of the EXOS ACE are each bound by the terms of this Notice and this Notice applies to all of the health information that identifies you and the care you receive at EXOS ACE facilities. The members of the EXOS ACE may share Protected Health Information ("PHI") with each other for treatment, payment, and/or health care operations of the EXOS ACE as permitted by HIPAA and this Notice. PHI is information that may identify you and that relates to your past, present, or future physical or mental health or health condition, the provision of health care products and services to you, or the payment for such services.

The members of the EXOS ACE are required by law to maintain the privacy of your medical information and to provide you with this Notice so you will understand how we may use or share your medical information and our legal duties and privacy practices relative to your medical information. The members of the EXOS ACE are required to follow the terms of the Notice currently in effect and will not use or share your information other than as described herein unless you tell us we can in writing. If you tell us we can, you may change your mind at any time by letting us know in writing.

If a breach occurs that may have comprised the privacy or security of your information, we will let you know promptly.

Following your receipt of this Notice, please sign, date and return it to the EXOS ACE. If you have any questions about this Notice, please contact EXOS ACE privacy official, at 2629 E. Rose Garden Lane, Phoenix, AZ, (623)-201-1433, privacyofficer@teamexos.com. A copy of this Notice will be posted on our website, www.teamexos.com, is available at our facility, and available upon request.

UNDERSTANDING YOUR HEALTH AND MEDICAL RECORD INFORMATION

Every time you access or receive services from an EXOS ACE site, documentation in your health/medical record is made. Typically, this record contains information about your condition and the treatment that we provide. We use and disclose this information to:

Plan your care and treatment

Document the care you received
Educate health professionals
Provide information for medical research
Business planning
Communicate with other health professionals involved in your care
Provide a means by which an insurance company can verify and pay for services
Provide information to public health officials
Evaluate and improve the care we provide

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following categories describe the ways we may use and disclose your medical information. We are unable to describe every possible way that we may use or disclose medical information under each category below. However, all of the ways we are permitted or required to use and disclose information will fall into one of the following categories:

For Treatment. We may use medical information about you in order to evaluate your health, diagnose medical conditions, and provide medical treatment. We may also share your health information with other professionals who are treating you such as doctors, nurses, therapists or other EXOS ACE personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know that you have diabetes because diabetes may slow the healing process. The doctor may also need to involve the dietitian, the pharmacist and therapist in your treatment plan. Different departments may share medical information about you in order to coordinate your care and provide you with medical treatment. We may also disclose medical information about you to people outside of the EXOS ACE who may be involved in your medical care after you leave our facility.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at an EXOS ACE site may be billed to you, an insurance company or a third party. For example, in order to receive payment, we may need to share information with your health plan about services that we provided to you. We may also tell your health plan about a treatment you are going to receive to obtain precertification, prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations and to Run Our Organization. We may use and disclose medical information about you for health care operations, to run our practice, improve your care, and contact you when necessary. This is necessary to ensure that all of our patients receive quality care. For example, we may use your medical information to contact you regarding appointments or to review our services for quality improvement activities. We may combine medical information about groups of patients to evaluate our programs. We may also disclose information to doctors, nurses, therapists and other personnel for review and learning purposes. We may remove information that identifies you so others may see it to study health care and health care delivery without learning your identity.

OTHER ALLOWABLE USES OF YOUR MEDICAL INFORMATION

Business Associates and Their Subcontractors. There are some services provided in our organization through contracts with business associates and their subcontractors. Examples include outside attorneys

or a copy service we may use when making copies of your health record. When we contract with a business associate to provide these services, we may disclose your medical information so they can perform the job we have asked them to do. We do require that the business associate and their subcontractors appropriately safeguard your information.

Directory Information. Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one treatment to those who received another for the same condition. A special approval process evaluates a proposed research project before it is implemented. Before we use or disclose your medical information for research, the project will have been approved through this process. We may, however, disclose medical information about you to people preparing to conduct a research study so long as the medical information they review does not leave the premises.

Health Care Benefits and Reminders. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Workers' Compensation. We may disclose medical information to the extent necessary to comply with laws relating to workers compensation or other similar programs. These programs provide benefits for work-related illness or injuries.

Reporting. Federal and state laws may require or permit us to disclose certain medical information related to the following:

- *Public health risks*: such as prevention or control of disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or problems with products; notifying people of product recalls; and notifying persons who may have been exposed to a disease.

- *Reporting abuse, neglect or domestic violence*: Notifying the appropriate government agency if we believe a resident has been the victim of abuse, neglect or domestic violence.

Health oversight. We may disclose medical information to a health oversight agency for activities such as audits, investigations, inspections and licensure, including the Department of Health and Human Services if they want to determine compliance with federal privacy law.

Judicial and Administrative proceedings. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process.

Law Enforcement. We may disclose your medical information for law enforcement purposes as

required by law or in response to a valid subpoena.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose medical information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. We will only disclose the information which is directly relevant to the person's involvement in your care or payment related to your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Funeral Directors, Medical Examiners and Coroners. We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary.

Organ and Tissue Donation. If you are an organ donor, we may disclose medical information to organizations that handle organ procurement to facilitate donation and transplantation.

As Required by Law. We may use or disclose medical information if the use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of the law.

We may, in accordance with the law, disclose medical information that we believe in good faith is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We would disclose such information to a person reasonably able to prevent or lessen the serious and imminent threat.

Specialized Government Functions. We may use or disclose medical information for specialized government functions such as to authorized federal officials so that they can provide protection to the U.S. President, other authorized persons or foreign heads of state, or to conduct special investigations; to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law; and if you are a member of the armed forces, we may disclose your information to the appropriate military authority.

Inmates or Individuals in Custody. If you are an inmate, then we may provide your information to a correctional institution if the information is necessary: (1) for the provision of health care; (2) for the health and safety of other individuals; (3) for the health and safety of officers and employees of the correctional institution; (4) for the health and safety of individuals responsible for transporting you; (5) for law enforcement on the premises; or (6) the administration and maintenance of the safety, security, and good order of the correctional institution.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made **only with your written authorization and permission**. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written permission. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records

of the care that we provided to you. You also will be unable to revoke written authorization to disclose medical information that you gave as a condition of obtaining insurance coverage where the law allows the insurer to contest a claim under the policy or the policy itself. We will not share your information for marketing purposes or sale of your information without your prior written authorization and permission.

YOUR MEDICAL INFORMATION RIGHTS

Although your health record is the physical property of the EXOS ACE, the information in your health record belongs to you. You have the following rights:

- **Right to Inspect and Copy.** With some exceptions, you have the right to review and copy your medical information and may ask to see or receive an electronic or paper copy of your medical record and other health information we may have about you.

  You must submit your request in writing to the EXOS ACE privacy official, ATTN: EXOS Data Protection Officer at 2629 E. Rose Garden Lane, Phoenix, AZ We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- **Right to Request Restrictions**. You may request that we not use or disclose your medical information for a particular reason related to treatment, payment, or health care operations or that we not disclose medical information to a family member or other specific relative or close friend involved in your care. If we are unable to agree to a requested restriction, for instance if it would affect your care, we are not required to comply with the request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you pay for a service out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer, unless applicable law requires that the information be shared.

  You must submit your request in writing to the EXOS ACE privacy official, ATTN: EXOS Data Protection Officer at 2629 E. Rose Garden Lane, Phoenix, AZ. In your request, you must tell us 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and 3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Alternative Locations and Alternative Means.** You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we contact you via mail to a post office box or that we contact you only at your home phone number.

  You must submit your request in writing to EXOS ACE privacy official, ATTN: Data Protection Officer at 2629 E. Rose Garden Lane, Phoenix, AZ. We will <u>not</u> ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Right to Amend or Correct.** If you believe that any medical information in your records is incorrect or if you believe that important information is missing, you may request that we amend

or correct the existing information or add the missing information. We may deny your request for an amendment and may also deny your request if it is not in writing or does not specify in what way the information is incorrect or incomplete. In addition, we may deny your request if you ask us to amend information that was not created by us, is not part of the medical information kept by us, or if the information is accurate and complete. If we deny your request, usually within 60 days, we will tell you why in writing.

You must submit your request in writing to EXOS ACE privacy official, EXOS ACE privacy official, ATTN: Data Protection Officer at 2629 E. Rose Garden Lane, Phoenix, AZ. In addition, you must provide a reason for your request.

- **Right to an Accounting of Disclosures.** You may request that we provide you with a written accounting of all disclosures made by us during a certain time period. This is a list of certain disclosures we made of your medical information. It will not include certain disclosures such as those made for treatment, payment or healthcare operations purposes.

  You must submit your request in writing to EXOS ACE privacy official, ATTN: Data Protection Officer at 2629 E. Rose Garden Lane, Phoenix, AZ. Your request must state a time period, which may not be longer than 6 years from the date the request is submitted. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists during any 12-month period, we may charge you for the costs of providing the list.

- **Right to Choose Someone to Act for You.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

- **Right to a Notice of a Breach.** You have a right to be notified upon a breach of any of your protected health information.

- **Right to Revoke Authorization.** If we ask or you provide us with an authorization to use or disclose your information, you can cancel that authorization at any time.

  You must submit your request in writing to EXOS ACE privacy official, ATTN: Data Protection Officer at 2629 E. Rose Garden Lane, Phoenix, AZ. You request will not affect any information that has already been shared.

- **Right to a Paper Copy of This Notice**. You have the right to obtain a paper copy of our Notice upon request, even if you agreed to receive the Notice electronically.

You must submit your request in writing to EXOS ACE privacy official, ATTN: Data Protection Officer at 2629 E. Rose Garden Lane, Phoenix, AZ.

YOUR CHOICES

- **Sharing Information with Family and Friends.** You have the right and choice to share information with your family, close friends, or others involved in your care, to share information during a disaster relief situation, and include your information in a directory. If you are unable to communicate to us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- **Fundraising.** You have the right and choice to tell us to contact you for fundraising efforts. We may contact you for fundraising efforts, but you can tell us not to contact you again. Treatment and payment will not be conditioned upon your choice as to fundraising communications.

- **Written Authorization Required.** We will not share your information for marketing purposes and we will not sell your information without first obtaining written authorization and permission from you. Similarly, we will never share any substance abuse treatment records, HIV information, genetic information, or venereal disease information without your written authorization and permission.

- **Psychotherapy Notes.** We do not create or maintain psychotherapy notes.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the EXOS ACE or with the Secretary of the Department of Health and Human Services Office of Civil Rights ("HHS").

To file a complaint with EXOS ACE, contact the EXOS ACE privacy official, using the information on page 1. All complaints must be submitted in writing. To file a complaint with HHS, send a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201, call 1-877-696-6775, or visit **www.hhs.gov/ocr/privacy/hipaa/complaints/.** There will be no retaliation for filing a complaint.

CHANGES TO THIS NOTICE

The EXOS ACE reserves the right to change its privacy practices as set forth in this Notice and to make the new provisions effective for all medical information that we maintain. If material changes are made to this Notice, the Notice will contain an effective date of the revisions and copies can be obtained by contacting our EXOS ACE privacy official, at 2629 E. Rose Garden Lane, Phoenix, AZ, (623)-201-1433, privacyofficer@teamexos.com. This Notice, and any revisions thereto, will also be made available on our web site, www.teamexos.com, at our facility, and upon request.

This Notice is Effective as of: February 1, 2019

ACKNOWLEDGEMENT OF RECEIPT OF EXOS'S NOTICE OF PRIVACY PRACTICES

I HAVE RECEIVED A COPY OF THE ABOVE NOTICE OF PRIVACY PRACTICES, AND I

UNDERSTAND MY RIGHTS AS SET FORTH THEREIN. I UNDERSTAND THAT THE EXOS ACE RESERVES THE RIGHT TO MODIFY ITS PRIVACY PRACTICES AS OUTLINED ABOVE.

_____

Name of Patient (Print or Type)

_____ _____

Signature of Patient | Date (mm/dd/yyyy)

_____ _____

Name of Patient Representative/Responsible Party (Print or Type) (Required if Patient is a minor or an adult who is unable to sign the form) | Relation to Patient

_____ _____

Signature of Patient Representative/Responsible Party (Required if Patient is a minor or an adult who is unable to sign the form) | Date (mm/dd/yyyy)