viva eve
THE WOMEN'S HEALTH EXPERTS

Patient Full Name

HIPAA JOINT PRIVACY NOTICE

THIS JOINT 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.

INTRODUCTION

This Joint Notice is being provided to you on behalf of one or more of the Viva Eve branded medical practices listed at the end of this notice and the employees and practitioners that work at the Practices with respect to services provided at the Practices. We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." "Protected health information" or "PHI" includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care. We will share protected health information with one another, as necessary, to carry out treatment, payment or health care operations relating to the services to be rendered at the Practice facilities.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a written copy of our most current privacy notice from the front desk as the Practice or you can access it on our website at www.vivaeve.com/patient-resources/patient-info-forms

PERMITTED USES AND DISCLOSURES

We can use or disclose your PHI for purposes of treatment, payment and health care operations. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

- Treatment means the provision, coordination or management of your health care, including consultations between health care providers relating to your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the exercise regimen appropriate for your treatment.

- Payment means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and other utilization review activities. For example we may need to provide PHI to your Third Party Payor to determine whether the proposed course of treatment will be covered or if necessary to obtain payment. Federal or state law may require us to obtain a written release from you prior to disclosing certain specially protected PHI for payment purposes, and we will ask you to sign a release when necessary under applicable law.

- Health care operations means the support functions of the Practice, related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your PHI to evaluate the performance of our staff when caring for you. We may also combine PHI about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose PHI for review and learning purposes. In addition, we may remove information that identifies you so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may also use your PHI in the following ways:

- To provide appointment reminders for treatment or medical care.

- To tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

- To contact your family and friends or any other individual identified by you to the extent directly related to such person's involvement in your care or the payment for your care. We may use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.
- When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.
- We will allow your family and friends to act on your behalf to pick-up filled prescriptions, medical supplies, X-rays, and similar forms of PHI, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.
- We may use or disclose your PHI for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.
- We will use or disclose PHI about you when required to do so by applicable law.
- In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or the Practice as required by applicable law.

Note: incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your PHI:

- Organ and Tissue Donation. If you are an organ donor, we may release PHI to organizations that handle organ procurement or transplantation as necessary to facilitate organ or tissue donation and transplantation.
- Military and Veterans. If you are a member of the Armed Forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.
- Worker's Compensation. We may release PHI about you for programs that provide benefits for work-related injuries or illnesses.
- Public Health Activities. We may disclose PHI about you for public health activities, including disclosures:
    - to prevent or control disease, injury or disability;
    - to report births and deaths;
    - to report child abuse or neglect;
    - to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;
    - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
    - to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure when required or authorized by law, such as when the patient agrees.

- Health Oversight Activities. We may disclose PHI to federal or state agencies that oversee our activities (e.g., providing health care, seeking payment, and civil rights).
- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI subject to certain limitations.
- Law Enforcement. We may release PHI if asked to do so by a law enforcement official:
    - In response to a court order, warrant, summons or similar process;
    - To identify or locate a suspect, fugitive, material witness, or missing person;
    - About the victim of a crime under certain limited circumstances;
    - About a death we believe may be the result of criminal conduct;
    - About criminal conduct on our premises; or
    - In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.
- Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner. We may also release PHI about patients to funeral directors as necessary to carry out their duties.
- National Security and Intelligence Activities. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, other national security activities authorized by law or to authorized federal officials so they may provide protection to the President or foreign heads of state.
- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the 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 or is necessary for law enforcement authorities to identify or apprehend an individual.

Note: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable state and federal law. Any disclosures of these types of records will be subject to these special protections.

OTHER USES OF YOUR HEALTH INFORMATION

Certain uses and disclosures of PHI will be made only with your written consent, including uses and/or disclosures: (a) of psychotherapy notes (where appropriate); (b) for marketing purposes; and (c) that constitute a sale of PHI under the Privacy Rule. Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written consent. You have the right to revoke that consent at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your consent.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of PHI for treatment, payment and health care operations. However, we are not required to agree to your request unless the disclosure is to a health plan in order to receive payment, the PHI pertains solely to your health care items or services for which you have paid the bill in full, and the disclosure is not otherwise required by law. To request a restriction, you may make your request in writing to the Privacy Officer.
2. You have the right to reasonably request to receive confidential communications of your PHI by alternative means or at alternative locations. To make such a request, you may submit your request in writing to the Privacy Officer.
3. You have the right to inspect and copy the PHI contained in our Practice records, except:
    i. for psychotherapy notes, (i.e., notes that have been recorded by a mental health professional documenting counseling sessions and have been separated from the rest of your medical record);
    ii. for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;

iii. for PHI involving laboratory tests when your access is restricted by law;

iv. if you are a prison inmate, and access would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, any officer, employee, or other person at the correctional institution or person responsible for transporting you;

v. if we obtained or created PHI as part of a research study, your access to the PHI may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;

vi. for PHI contained in records kept by a federal agency or contractor when your access is restricted by law; and

vii. for PHI obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

In order to inspect or obtain a copy your PHI, you may submit your request in writing to the Medical Records Custodian. If you request a copy, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

We may also deny a request for access to PHI under certain circumstances if there is a potential for harm to yourself or others. If we deny a request for access for this purpose, you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request an amendment to your PHI but we may deny your request for amendment, if we determine that the PHI or record that is the subject of the request:

   i. was not created by us, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;

   ii. is not part of your medical or billing records or other records used to make decisions about you;

   iii. is not available for inspection as set forth above; or

   iv. is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your PHI, you must submit your request in writing to Medical Record Custodian at our Practice, along with a description of the reason for your request.

5. You have the right to receive an accounting of disclosures of PHI made by us to individuals or entities other than to you for the six years prior to your request, except for disclosures:

   i. to carry out treatment, payment and health care operations as provided above;

   ii. incidental to a use or disclosure otherwise permitted or required by applicable law;

   iii. pursuant to your written authorization;

   iv. to persons involved in your care or for other notification purposes as provided by law;

   v. for national security or intelligence purposes as provided by law;

   vi. to correctional institutions or law enforcement officials as provided by law;

   vii. as part of a limited data set as provided by law.

   To request an accounting of disclosures of your PHI, you must submit your request in writing to the Privacy Officer at our Practice. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

6. You have the right to receive a notification if there is a breach of your unsecured PHI that requires notification under the Privacy Rule.

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COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact the Practice Privacy Officer, Marion Marino, at 718- 897-5331 or 108-16 63rd Rd, Queens, NY 11375. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of the U. S. Department of Health and Human Services.

CONTACT PERSON

If you have any questions or would like further information about this notice, please contact the Practice Privacy Officer, Marion Marino, at 718- 897-5331 or 108-16 63rd Rd, Queens, NY 11375.

This notice is effective as of September 13, 2022.

VIVA EVE MEDICAL PRACTICES

Forest Hills Medical Services, PC
J. Gohar Medical, PC
Madison Medical Services, PC
Meridian Medical Services, PLLC
1986 Medical, PLLC
9909 Medical, PLLC

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ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA OR OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (**INCLUDING BREACH OF FIDUCIARY DUTY**) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Assignment of Insurance Benefits - Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and the Provider's representatives ("My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- File medical claims with the health plan
- File appeals and grievances with the health plan
- Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan
- Institute any necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary (or me as guardian of the patient if the patient is a minor)

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. **This constitutes an express and knowing assignment of ERISA breach and/or fiduciary duty claims and other legal and/or administrative claims.** I authorize communication with the Provider and its authorized representatives by email, phone and/or text. I understand I can revoke this authorization in writing at any time.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

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HARDSHIP POLICY

The Practice offers this Financial Hardship Policy in which clients of the practice may receive a reduction of their client financial responsibility based solely upon their financial condition and their ability to pay. This policy was enacted for those clients that truly cannot afford to pay for services due to financial hardship.

Federal Law has consistently provided an important exception to the general prohibition against waiving cost-sharing amounts such as coinsurance and deductibles in situations of financial hardship. Specifically. under federal fraud and abuse laws, such cost-sharing amounts may be waived as long as: (i) the waiver is not offered as part of any advertisement or solicitation; (ii) the party offering the waiver does not routinely waive cost-sharing amounts; and (iii) the party waives the cost-sharing amounts after determining in good faith that the beneficiary is in financial need or reasonable collection efforts have failed. Section 1128A(i)(6)(A) of the Act, 42 U.S.C §1320a-7a(i)(6)(A).”

This Financial Hardship Policy has been specifically reviewed and updated in accordance with these federal regulations and believed to be fully in compliance with Section 1128A(a)(S) of the Social Security Act (the “Act”), or under the exclusion authority of Section 1128(b)(7) of the Act, or the civil monetary penalty provision at section 1128(a)(7) of the Act, as those sections relate to the commission of acts described in section 1128B(b) of the Act, and the federal Anti-Kickback Statute.

It is the Financial Hardship Policy of the Practice to collect all applicable co-pays, deductibles, coinsurance or other amounts owed by a client (or his/her legal representative). A client is legally responsible for all charges regardless of any applicable insurance coverage or third-party payment or reimbursement without regard to the insured, uninsured or under-insured. A client’s obligation to pay his/her co-pay, coinsurance and/or deductible shall only be waived or reduced as permitted by this Policy, federal and state law and/or payer contractual provisions.

This Financial Hardship Policy shall be the authority governing all of our financial practices for all types of claims and health programs.

This Financial Hardship Policy is communicated to every employee of our healthcare practice, and is available for inspection and reference at our practice’s administrative office for compliance and inspection purposes.

This Financial Hardship Policy is disclosed to all prospective clients and signed by the clients prior to services being rendered.

Each client’s indigency status is determined on an individual basis solely based on each individual’s financial and medical needs as defined above in accordance with all governing federal and state laws. For clients unable to pay fully for services, financial assistance will be provided based solely upon the client’s financial ability to pay. The Financial Assistance Policy shall be applied uniformly to all clients regardless of the type of insurance they possess, whether or not they are uninsured, and regardless of their race, religion, age. disability, gender and sexual preference.

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FINANCIAL POLICY

I. Introduction:

The Practice are dedicated to providing the best value to our patients. Our general policy is that we will not overburden our clients with the costs of our care. This document explains your rights as a patient and what you can expect from us regarding your healthcare costs. We are always ready to work with you to ensure you have access to our quality services at a price that is fair. Please read this policy and indicate that you have understood and agreed to it by signing at the bottom.

II. Out-of-Network Disclosure:

In some cases, we participate as Out-of-Network providers with all insurances that offer OON benefits. This means that we accept plans with out of network coverage, but do not have contracts in place with those plans defining what we will accept as full payment for our services. As a result, we have an obligation to bill our patients for their portion of the responsibility on each claim. This includes all deductibles, copays. and co-insurances. This may also include “Balance Bills”.

III. Financial Agreement

You agree by signing this document to be responsible for your patient cost share and that you will ultimately be responsible for our Practice’s charge after all payments are received, unless you qualify for financial assistance under the Practice’s Financial Hardship Policy. You agree to pay our invoices for coinsurance, deductibles and cost share amounts upon receipt of our invoice or statement. If you fail to pay your coinsurance, deductibles and cost share amounts upon receipt of our invoice or statement, you may be subject to collection activity and will be further responsible for interest on the balance owed the Practice at 2% per month or, if lower, the maximum rate allowable by applicable law.

IV. Balance Bill Policy (Out of Network Claims Only)

In many instances, the health plans do not pay our charges for medical services in full. We recognize that, as a result, we have an obligation to bill our out-of-network patients the difference between our charges and all payments received. This is commonly referred to as a “Balance Bill”. The Balance Bill amount owed by the patient in some cases is not properly stated on the health plan’s EOBs and remittances. We do not balance bill patients until all medical claims are billed to your health plan and we take all necessary steps to ensure that your claims are paid at rates set forth in your health plan, which, in many cases, includes our filing appeals with your health plan on your behalf.

We have created this Balance Bill Policy to comply with state and federal laws which require the Balance Bill of clients for out-of-network claims. This Policy applies to all of our facilities that you may encounter during your complete course of treatment.

Once we feel confident that no further payment will be made by the health plan, we will balance the patient the difference between our charge and all payments received.

We recognize that not all of our patients will be able to afford their patient responsibility for the balance bill, their deductibles, copayments and coinsurance. As a result, we have created a financial hardship policy which legally permits us to reduce and, in some cases, waive your patient responsibility. Many of you will be offered financial assistance prior to your first visit. If you believe you might qualify for financial assistance due to financial hardship, please ask our staff for a copy of our Financial Hardship Policy.

Balance Bill Letters will not be sent to patients who have health plans that we participate with as in-network providers.

The statute of limitations for debt collection in the State of New York is six (6) years for contracts in writing. Accordingly, we will only seek collection of the Balance Bill that were incurred no more than six (6) years from the date of the balance bill statement was sent. Thank you for being our patient.

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FINANCIAL ASSISTANCE POLICY

I. Financial Assistance Policy

For clients that have experienced recent hardship that impact their income and ability to pay for services, charity care discounts shall be considered at the sole discretion of the Practice's Charity Care Committee. These circumstances may include, but are not limited to, recent:

- loss of employment
- death in family
- physical disability
- mental illness
- recent financial hardship

ALL CLIENTS MAY BE REQUIRED TO CERTIFY TO THEIR ADJUSTED GROSS INCOME AS STATED ON THEIR MOST RECENT FEDERAL INCOME TAX RETURN FOR THE MOST RECENT TAX PERIOD TO EARN CHARITY CARE DISCOUNTS. CHARITY CARE DISCOUNTS SHALL BE APPLIED TO THAT PORTION OF CLIENT RESPONSIBILITY SUCH AS DEDUCTIBLES, COINSURANCE OR OTHER NON-COVERED SERVICES ONLY. CLIENTS SHALL NOT RECEIVE ANY DISCOUNTS ON AMOUNTS PAID BY HEALTH INSURANCE COMPANIES OF THE CLIENTS OR ON INSURANCE CHECKS TURNED OVER TO THE PRACTICE BY THE CLIENT.

II. Conditions on Charity Care Discounts

Discounts provided under this policy are conditioned upon the continued cooperation of the client and/or guarantor in the Provider's pursuit of fair reimbursement from the insurer or payor of benefits. Failure to cooperate with such pursuits shall result in forfeiture of discounts provided.

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PATIENT AUTHORIZATION TO OBTAIN
SUMMARY PLAN DESCRIPTION & 5500 FORM

I hereby direct you to forward to the Practice and their authorized representatives the following governing plan documents for the purpose of applicability of compliance with PPACA:

1. Summary Plan Description (SPD)
2. 5500 Form (Plan Annual Report)
3. Certified Copy of Certificate for PPACA Grandfathered Plan.

Please forward to the below address immediately -
Practice Mailing Address:

108-16 63rd Road,
Forest Hills, NY 11375

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EMAIL AND TEXT POLICY

I hereby voluntarily provide my email and cell telephone number to the Practices.

I agree to permit the Practices and their Authorized Representatives to communicate with me by email and text messages with respect to the medical claims submitted to my health plan and with respect to any balances due to the Practices after health plan and other payments received by the Practices and for balances not covered by my health plan, coinsurance, deductibles or any other balance deemed patient responsibility.

To be clear, I am consenting to communication by email as required by 15 U.S.C. §7001 and related state regulations and statutes. I understand that I have the option to receive any communication on paper or non-electronic form. In such case, I will notify the Practices in writing of this request. I understand that my consent is continuous. However, I understand further that I may terminate my consent to email communication in writing to the Practices There are no hardware or software requirements needed to receive email communication from the the Practices or their Authorized Representatives other than an active email account obtained from a vendor that provides such email accounts.

I understand the Practices and their Authorized Representatives will not sell or rent my email address or any other personal information collected on this consent.

Provider means any one or more of the following medical practices:

Forest Hills Medical Services, PC
J. Gohar Medical, PC
Madison Medical Services, PC
Meridian Medical Services, PLLC
1986 Medical, PLLC
9909 Medical, PLLC

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Summary of Practice Policies:

- HIPAA Joint Privacy Notice
- Assignment of Benefits and Assignments of Rights to Pursue ERISA and Other Legal and Administrative Claims Associated with My Health Insurance or Health Benefits Plan (Including Breach of Fiduciary Duty) and Designation, of Authorized Representative
- Hardship Policy
- Financial Policy
- Financial Assistance Policy
- Text and Email Policy
- Patient Authorization to Obtain Summary Plan Description & 5500 Form

I have reviewed the practice polices described above and I agree to abide by these policies. I agree to permit the practice to communicate with me by phone, text and/or email and my email address is: _____

I agree to and consent to the terms set forth in the Assignment of Benefits.

_____ Signature of Patient