

PENTAHEALTH GENERAL CONSENT FORM

I have read and understood each paragraph below, and by signing give consent voluntarily.

I accept and I intend the signature(s) below to be legally binding and the equivalent of my handwritten signature.

Patient signing:

@DBLINK(EPT,,2,1,11,2)@

PN: @DBLINK(EPT,123)@

Legal Patient Name/ Preferred Name(PN)

Collect Required PatientSign Signature

Patient Signature

Legally Authorized Representative Signing

Collect LegalAuthName Signature

Name

Collect LegalAuthSign Signature

Signature

Collect LegRel Signature

Relationship to Patient

CONSENT TO CARE: I present myself for outpatient care and I voluntarily consent to care including routine tests and treatment. I know that no guarantees have been made to me about the results of the care provided.

Consent to Using and Participating in Telemedicine and Telehealth. I agree that some of my medical care, including diagnosis, treatment and other related services, may be provided through the use of electronic communications and technologies, often referred to as “telemedicine” or “telehealth.” Telemedicine includes but is not limited to audio-video conferencing, transmission of photographs or other images, patient portals, telephone, email and text-based consultations, and remote monitoring. I

acknowledge that, as with any medical treatment, there are potential risks with telemedicine that may include, for example technical problems with the information transmission and equipment failures that could result in lost information or delays in treatment. The alternatives to the use of telemedicine may include face-to-face encounters or receiving my care in another way. I understand that I have a right to refuse or withdraw my consent to participate in telemedicine in the course of my medical care at any time, without affecting my right to future medical care. Telemedicine services are generally billed in the same manner as regular provider services.

CONSENT TO USE AND DISCLOSE PERSONAL HEALTH INFORMATION: I understand and consent that PentaHealth is permitted to use and disclose health information about me in any form for **treatment, payment, and healthcare operations** and as otherwise allowed by law. This includes sharing my health information with:

Non-PentaHealth or outside providers involved in my care, and family members or friends involved in my care.

People or parties responsible for payment for the care I receive, such as insurance companies, managed care companies, government programs and agencies such as Medicare, and each of their agents or auditors.

SPECIFIC CONSENT TO USE AND DISCLOSE SPECIAL RECORDS:

I understand that Federal and state law specially protect health information and records relating to treatment for mental illness, HIV or AIDS, and/or drug or alcohol abuse ("Special Records"). Such laws allow PentaHealth to use and share Special Records for my care and treatment and for other specific purposes. In other circumstances, PentaHealth will obtain special patient consent to release records.

NOTICE OF PRIVACY PRACTICES: I have been given a copy of PentaHealth's Notice of Privacy Practices, which explains in more detail how my health information may be used and/or disclosed.

Exclusive Venue for Healthcare-Related Claims: Although Pennsylvania law may permit filing lawsuits or legal action in other places, I agree that any lawsuit or legal action which is in any way linked to the health care that I receive from PentaHealth or its agents/employees must be filed in the County in which the health care at issue received from PentaHealth and/or its agents/employees was given.

ASSIGNMENTS OF BENEFITS: In exchange for the care and services I am receiving from PentaHealth, I hereby give and assign to PentaHealth the right to receive payment directly for all insurance and other health benefits to which I am entitled, and/or which may be payable on my behalf. I understand that this is called an "assignment of benefits" and that PentaHealth and/or its providers may be called my "assignees." I agree that they can sue anyone in their own names as my assignee and obtain payment for charges relating to my care and payment for lawyers' fees resulting from collection efforts. I understand that I may be required to pay for charges for my care that others do not pay on my behalf.

MEDICARE BENEFITS: I request that payment of Medicare benefits be made on my behalf to PentaHealth or its providers for any care or services provided to me. I authorize them to give the Centers for Medicare & Medicaid Services and its agents any information about me (or the person I signed for) needed to determine Medicare benefits. I have provided accurate information about Medicare secondary payors.

FINANCIAL RESPONSIBILITY: Even if I have insurance, I may be responsible for charges for my care delivered either in-person or via telemedicine that others do not pay on my behalf. I agree that within forty-five (45) days after PentaHealth provides care to me (or the person I signed for), or the bill for such care is given to me or whomever is responsible for payment, I will pay PentaHealth any unpaid charges. If the matter is sent to a collection agency or lawyer for collection, I will pay the outstanding charges and all lawyers' fees and collection expenses.

SEVERABILITY: If any part of this consent form is declared to be invalid, illegal or unenforceable, the rest of this consent form will not be invalid. This does not take away any rights I, my employer, or my insurance company may have under any existing contracts with PentaHealth, or any statutory rights I may have.

HIPAA NOTICE OF PRIVACY PRACTICES – July 2021

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.

WE ARE COMMITTED TO YOUR PRIVACY

We understand that information about you and your health is very personal. We strive to protect our patients' privacy. We are required by law to maintain the privacy of our patients' protected health information ("PHI"). We are also required to provide notice of our legal duties and privacy practices with respect to PHI and to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of this Notice and to make a new Notice effective for all PHI we maintain.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION THAT DO NOT REQUIRE AN AUTHORIZATION

Treatment. For example, doctors, nurses, and other staff members involved in your care will use and disclose your PHI to coordinate your care or to plan a course of treatment for you.

Payment. For example, we may disclose information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you.

Health Care Operations. For example, we may disclose your PHI for billing or interpreter support. We may use your PHI to conduct an evaluation of the treatment and services provided or to review staff performance. We may disclose your PHI for education and training purposes to doctors, nurses, technicians, medical students, residents, fellows and others.

Health Information Exchanges. We participate in initiatives to facilitate electronic sharing of patient information, including but not limited to Health Information Exchanges (HIEs). HIEs involve coordinated information sharing among HIE members for purposes of treatment, payment, and health care operations. You may opt out of PentaHealth's information sharing through its HIE activities.

To Persons Involved in Your Care. As long as you do not object, we may, based on our professional judgment, disclose your PHI to a family member or other person if they are

involved in your care or paying for your care. Similarly, we may also disclose limited PHI to an entity authorized to assist in disaster relief efforts for the purpose of coordinating notification to someone responsible for your care of your general condition or location.

Communicating with You.

We will use your PHI to communicate with you about a number of important topics, including information about appointments, your care, treatment options and other health-related services, payment for your care.

We urge you to sign up for our patient portal to send and receive communications conveniently and securely and to share your preferences for how we contact you. The patient portal is: <https://pentahealth.com/mychart>. We may also contact you at the email, phone number or address that you provide, including via text messages, for these communications. If your contact information changes, it is important that you let us know. Texting and email are not 100% secure. Regarding text messages, please note that message and data rates may apply and you will have an opportunity to opt out.

Business Associates. At times, we need to disclose your PHI to persons or organizations outside of PentaHealth who assist us with our payment/billing activities and health care operations. We require these business associates and their subcontractors to appropriately safeguard your PHI.

Other Uses and Disclosures. We may be permitted or required by law to make certain other uses and disclosures of your PHI without your authorization. Subject to conditions specified by law, we may release your PHI:

- for any purpose required by law
- for public health activities, including required reporting of disease, injury, birth and death, for required public health investigations, and to report adverse events or enable product recalls
- to government agencies if we suspect child/elder adult abuse or neglect. We may also release your PHI to government agencies if we believe you are a victim of abuse, neglect or domestic violence
- to your employer when we have provided screenings and health care at their request for occupational health and safety
- to a government oversight agency conducting audits, investigations, inspections and related oversight functions
- in emergencies, such as to prevent a serious and imminent threat to a person or the public
- if required by a court or administrative order, subpoena or discovery request
- for law enforcement purposes, including to law enforcement officials to identify or locate suspects, fugitives or witnesses, or victims of crime
- to coroners, medical examiners and funeral directors
- if necessary to arrange organ or tissue donation or transplant
- for national security, intelligence, or protective services activities
- for purposes related to your workers' compensation benefits

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION BASED ON A SIGNED AUTHORIZATION

Except as outlined above, we will not use or disclose your PHI for any other purpose unless you have signed a form authorizing the use or disclosure. You may revoke an authorization in writing, except to the extent we have already relied upon it.

In some situations, a signed authorization form is required for uses and disclosures of your PHI,

including:

- most uses and disclosures of psychotherapy notes
- uses and disclosures for marketing purposes
- disclosures that constitute the sale of PHI
- uses and disclosures for certain research protocols
- as required by privacy law. The confidentiality of substance use disorder and mental health treatment records as well as HIV-related information maintained by us is specifically protected by state and/or federal law and regulations. Generally, we may not disclose such information unless you consent in writing, the disclosure is allowed by a court order, or in other limited, regulated circumstances.

YOUR RIGHTS

Access to Your PHI. Generally, you can access and inspect paper or electronic copies of certain PHI that we maintain about you. You may readily access much of your health information without charge using the patient portal, which is: <https://pentahealth.com/mychart>. In line with set fees under federal and state law, we may charge you for a copy of your medical records.

Amendments to Your PHI. You can request amendments, or changes, to certain PHI that we maintain about you that you think may be incorrect or incomplete. All requests for changes must be in writing, signed by you or your representative, and state the reasons for the request. If we decide to make an amendment, we may also notify others who have copies of the information about the change. Note that even if we accept your request, we may not delete any information already documented in your medical record.

Accounting for Disclosures of Your PHI. In accordance with applicable law, you can ask for an accounting of certain disclosures made by us of your PHI. This request must be in writing and signed by you or your representative. This does not include disclosures made for purposes of treatment, payment, or health care operations or for certain other limited exceptions. An accounting will include disclosures made in the six years prior to the date of a request.

Restrictions on Use and Disclosure of Your PHI. You can request restrictions on certain of our uses and disclosures of your PHI for treatment, payment, or health care operations. We are not required to agree but will attempt to accommodate reasonable requests when appropriate.

Restrictions on Disclosures to Health Plans. You can request a restriction on certain disclosures of your PHI to your health plan. We are only required to honor such requests when services subject to the request are paid in full. Such requests must be made in writing and identify the services to which the restriction will apply.

Breach Notification. We are required to notify you in writing of any breach of your unsecured PHI without unreasonable delay and no later than 60 days after we discover the breach.

Paper Copy of Notice. You can obtain a paper copy of this Notice, even if you agreed to receive an electronic copy. This Notice is available on our website at <https://www.PentaHealth.com>.