

Means of Communication

Patient: _____ DOB _____

Knoll Clinic may communicate with me as follows about my appointments, test results, treatment options, breach notification, or any other matter related to my treatment or payment of my treatment. **If you decline to give such permission, check "NO." At least one box must be marked "YES."**

YES NO

___ ___ Calling me at my home phone number: Phone #: _____

___ ___ Leaving a message on my home voice mail.

___ ___ Calling me at my work phone number. Phone #: _____

___ ___ Leaving a message on my work voicemail.

___ ___ Calling me at my cell phone number. Phone #: _____

___ ___ Texting me at my cell phone number.

(by selecting "no" patients may still receive general information texts related to closings or general office information or changes)

___ ___ Leaving a message on my cell phone number.

___ ___ E-mailing me at _____

(I understand that such communications will not be encrypted)

___ ___ Leaving a message with any individual who answers my phone(s)

Please notify the staff if you wish to make any changes to these directives.

I understand and agree to the Means of Communication as above.

Patient/Guardian Signature: _____

Printed: _____

Date: _____

HIPPA Persons involved in care or payment for care:

I authorize Knoll Clinic to disclose my protected health information (including scheduled/rescheduled appointments, test results, diagnoses, treatment plan, billing questions, etc.) to the following people involved in my care or payment of care. *If you decline such permission, leave the following blank.*

Signature _____ **Date** _____

Name _____ Relationship to patient _____ Phone _____

Name _____ Relationship to patient _____ Phone _____

Name _____ Relationship to patient _____ Phone _____

ALL PATIENTS MUST SIGN

I ACKNOWLEDGE THAT I HAVE RECEIVED AND UNDERSTAND THE
KNOLL CLINIC'S NOTICE OF PRIVACY PRACTICES WITH THE EFFECTIVE
DATE 2/13/2026.

X _____

Relationship If Not Patient Date

ASSIGNMENT OF BENEFITS: I hereby authorize payment of my medical benefits, including, but not limited to, Medigap benefits, private insurance, Medicaid and any and all other benefits payable by an insurer or other third party to Knoll Clinic LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all records necessary to secure a secure payment. If I am insured by Medicare, I request that payment of authorized Medicare benefits be made on my behalf to Knoll Clinic LLC. for any services provided to me. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I agree to be personally responsible for payment of services which are not covered by insurance and further agree to pay collection expenses and attorney's fees necessary to collect payment.

Signature: X _____ **Date:** _____

CONSENT FOR TREATMENT: The following information is to be completed by the patient, or the patient's legally authorized representative/parent.

I consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative. I understand the Knoll Clinic will share patient health information according to federal and state law for treatment, payment, and operations.

Signature: X _____ **Date:** _____

Past Medical History					
Patient Name: _____		DOB: _____			
Cardiac <input type="checkbox"/> Angina <input type="checkbox"/> Aortic Aneurysm <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Carotid Artery Stenosis <input type="checkbox"/> Congenital Heart Disorder <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Deep Vein Thrombosis (blood clot) <input type="checkbox"/> Heart Valve Disease- which valve: _____ <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hypertension <input type="checkbox"/> Irregular Heart rate <input type="checkbox"/> Myocardial Infarction <input type="checkbox"/> Peripheral Artery Disease (PAD) <input type="checkbox"/> Peripheral Vascular Disease (PVD) <input type="checkbox"/> Varicose Veins	Pulmonology <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Chronic Cough <input type="checkbox"/> COPD <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Interstitial Lung Disease <input type="checkbox"/> Mesothelioma <input type="checkbox"/> Obstructive Sleep Apnea (OSA) <input type="checkbox"/> Pulmonary Embolism <input type="checkbox"/> Pulmonary Fibrosis <input type="checkbox"/> Pulmonary Hypertension <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Sleep Disorders <input type="checkbox"/> Tuberculosis	GI <input type="checkbox"/> Anal Fissures <input type="checkbox"/> Barrett's Esophagus <input type="checkbox"/> Bowel Changes <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Change in Stool Size or Shape <input type="checkbox"/> Cholelithiasis <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Colon Polyps <input type="checkbox"/> Constipation <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Diarrhea <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Fatty Liver Disease <input type="checkbox"/> Gallstones <input type="checkbox"/> Gastritis <input type="checkbox"/> GERD (acid reflux) <input type="checkbox"/> GI Bleed <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hep A <input type="checkbox"/> Hep B <input type="checkbox"/> Hep C <input type="checkbox"/> Irritable Bowel Syndrome (IBS) <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Peptic Ulcers <input type="checkbox"/> Ulcerative Colitis	Renal/Genitourinary <input type="checkbox"/> Benign Prostatic Hypertrophy (BPH) <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Cystocele <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Frequent Urinary Tract Infections <input type="checkbox"/> Heavy Menstrual Bleeding <input type="checkbox"/> Interstitial Cystitis <input type="checkbox"/> Irregular Periods <input type="checkbox"/> Menstrual Cramping <input type="checkbox"/> Nocturia (frequent urination at night) <input type="checkbox"/> Overactive Bladder <input type="checkbox"/> Pelvic Floor Disorders <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Polycystic Ovary Syndrome <input type="checkbox"/> Renal Failure <input type="checkbox"/> Renal Stones <input type="checkbox"/> Urinary Incontinence	Neurological/Genetic <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's) <input type="checkbox"/> Asperger's <input type="checkbox"/> Autism <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Cerebrovascular Accident <input type="checkbox"/> Dementia <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Essential Tremor <input type="checkbox"/> Fragile X Syndrome <input type="checkbox"/> Headaches <input type="checkbox"/> Huntington's Chorea <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Neuropathy- Location: _____ <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Pervasive Developmental Delay <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Transient Ischemic Attack <input type="checkbox"/> Traumatic Brain Injury	Endocrinology <input type="checkbox"/> Addison's Disease <input type="checkbox"/> Carcinoid Syndrome <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Cushing's Disease <input type="checkbox"/> Diabetes Type 1 <input type="checkbox"/> Diabetes Type 2 <input type="checkbox"/> Grave's Disease <input type="checkbox"/> Hashimoto's Disease <input type="checkbox"/> Hyperinsulinemia <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypogonadism- Male <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Infection Problems: _____ <input type="checkbox"/> Insulin Resistance <input type="checkbox"/> Menopause <input type="checkbox"/> Metabolic Syndrome <input type="checkbox"/> Panhypopituitarism <input type="checkbox"/> Perimenopause
Hematologic <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Clotting Disorders <input type="checkbox"/> Factor V Leiden <input type="checkbox"/> Hemochromatosis <input type="checkbox"/> Hemophilia <input type="checkbox"/> Iron Deficiency <input type="checkbox"/> Myelofibrosis <input type="checkbox"/> Pernicious Anemia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Sickle Cell Trait <input type="checkbox"/> Thalassemia <input type="checkbox"/> Thrombocytopenia (low platelets) <input type="checkbox"/> Vitamin B12 Deficiency <input type="checkbox"/> Vitamin D Deficiency <input type="checkbox"/> Von Willebrand Disease	Musculoskeletal <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Autoimmune Disorders: _____ <input type="checkbox"/> Degenerative Disc Disease: _____ <input type="checkbox"/> Dermatomyositis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Gout <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis - with or without fracture <input type="checkbox"/> Paget's Disease <input type="checkbox"/> Polymyalgia Rheumatic <input type="checkbox"/> Polymyositis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Scoliosis <input type="checkbox"/> Sjogren's Syndrome <input type="checkbox"/> Spinal Stenosis: _____ <input type="checkbox"/> Systemic Lupus Erythematosus	Allergy/Immune/Derm <input type="checkbox"/> Acne <input type="checkbox"/> AIDS <input type="checkbox"/> Alopecia <input type="checkbox"/> Angioedema <input type="checkbox"/> Cold Sores <input type="checkbox"/> Contact Allergy <input type="checkbox"/> Eczema <input type="checkbox"/> Genital Herpes <input type="checkbox"/> HIV <input type="checkbox"/> Immune Deficiency <input type="checkbox"/> Psoriasis <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Shingles	Psychiatric <input type="checkbox"/> ADHD <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anorexia <input type="checkbox"/> Anxiety <input type="checkbox"/> Binge Eating Disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Bulimia <input type="checkbox"/> Depression <input type="checkbox"/> Drug Abuse- List <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Personality Disorder <input type="checkbox"/> PTSD <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Suicidal	Eyes/Hearing <input type="checkbox"/> Visual Impairment- -- Glasses - Contacts - Lasix - Other:- _____ <input type="checkbox"/> Glaucoma- - Right - Left - Both <input type="checkbox"/> Hearing Impairment -Hearing Aids: - Right - Left - Both	Cancer/Other <input type="checkbox"/> Cancer Type: _____ <input type="checkbox"/> Other Issues Not Listed: _____

Family History:	F	M	S	C	F	P	N	M	P	N	M	Family History:	F	M	S	C	P	P	M	M	P	P	M	M
Disease:	a	o	i	h	a	a	a	a	a	a	a	Disease:	a	o	i	h	a	a	a	a	a	a	a	a
	t	t	b	i	t	t	t	t	t	t	t		t	t	b	i	t	t	t	t	t	t	t	t
	h	h	l	l	t	t	t	t	t	t	t		h	h	l	l	t	t	t	t	t	t	t	t
	e	e	i	r	r	r	r	r	r	r	r		e	e	i	r	r	r	r	r	r	r	r	r
	r	r	n	e	a	a	a	a	a	a	a		r	r	n	e	a	a	a	a	a	a	a	a
Aortic Aneurysm												CVA Stroke/TIA												
Arrhythmia												Dementia												
												Down Syndrome												
Cardiomyopathy												Essential Tremor												
Carotid Artery Stenosis												Huntington's Chorea												
Congestive Heart Failure												Migraines												
Coronary Artery Disease												Multiple Sclerosis												
Deep Vein Thrombosis												Muscular Dystrophy												
Heart attack												Myasthenia Gravis												
Hypertension												Parkinson's Disease												
Hyperlipidemia												Seizure Disorder												
Peripheral Artery Disease												Spina Bifida												
Peripheral Vascular Disease												Addison's Disease												
Sudden Cardiac Death												Cushing's Disease												
Asthma												Diabetes Type 1												
COPD												Diabetes Type 2												
Cystic Fibrosis												Grave's Disease												
Emphysema												Hashimoto's Disease												
Interstitial Lung Disease												Hyperthyroidism												
Obstructive Sleep Apnea												Hypothyroidism												
Pulmonary Embolism												Bleeding Disorders												
Pulmonary Fibrosis												Clotting Disorders												
Pulmonary Hypertension												Factor V Leiden												
Sleep Disorders												Hemochromatosis												
Barrett's Esophagus												Hemophilia												
Celiac Disease												Iron Deficiency												
Colon Polyps												Pernicious Anemia												
Crohn's Disease												Sickle Cell Disease												
Diverticulitis												Sickle Cell Trait												
Fatty Liver Disease												Thalassemia												
GERD (acid reflux)												Von Willebrand Disease												
Irritable Bowel Syndrome												Fibromyalgia												
Pancreatitis												Osteoarthritis												
Ulcerative Colitis												Osteoporosis/Osteopenia												
Chronic Kidney Disease												Rheumatoid Arthritis												
Polycystic Kidney Disease												Sjogren's Syndrome												
Polycystic Ovary Syndrome												Lupus												
Renal Failure												Eczema												
Alzheimer's Disease												Alcoholism												
ALS/Lou Gehrig's												Anxiety												
Asperger's												Depression												
Autism												Drug Abuse												
Cerebral Palsy												Schizophrenia												
Early Death:												Other: _____												

Cancer Please List Type and Family Member: _____

Social History:

Occupation: _____	
Marital Status:	Single Divorced Separated Married Widowed Unmarried, live together Other: _____
Do you Have Children?	YES NO LIST: _____
Who Lives With You?	List: _____ _____
Hobbies/Sports:	List: _____

Exercise:

Do you Exercise?	Yes No
Type of Exercise:	List: _____
How Often?	____ Days/Week Occasionally Rarely Never

Tobacco Status:

Do you currently smoke cigarettes?	Yes No
If yes, how many packs per day?	____ Pack(s)/Day or ____ #Cigarettes/how often
Do you vape?	Yes No
If yes, how often?	Daily or if occasionally how often? _____
Do you use nicotine patches/pouches?	Yes No Patches or Pouches
How many patches/pouches per day?	How many Patches/Pouches: _____
Have you used nicotine/vaping/cigarettes in the past?	Which one: _____ How Long: _____ Quit Date: _____
Are you currently exposed to smoke?	Yes No

Alcohol Status:

Do you currently drink any alcohol?	Yes No
If yes, how often?	____ Days/Week
How many drinks in one sitting?	____ Drinks/Occasion
What type of alcohol?	Beer-Malt Liquor-Wine-Wine Coolers-Mixed Drinks- Hard Liquor-Seltzers

Caffeine Status:

Do you intake any caffeine?	Yes No
Type?	Coffee Tea Soda Energy Drinks
How much?	____ Servings/day or rarely or occasionally

Drug Usage Status:

Have you ever used street drugs?	Yes No
If yes, which ones?	IV Drugs Cocaine Heroin Marijuana Downers Inhalants Other: _____
Are you still using drugs?	Yes No

Life Style:

Are you sexually active?	Yes No	Do you have any concerns for your safety?	Yes No
Are you currently using any birth control?	Yes No Condoms-Pill-IUD-Vasectomy- Tubes Tied Other: _____	Do you have a living will?	Yes No
Do you wear sunscreen?	Yes No	Do you have a Durable Power of Attorney?	Yes No Who: _____
Do you wear your seatbelt?	Yes No		

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (“HIPAA”) NOTICE OF PRIVACY PRACTICES (“NOTICE”)

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. FURTHER DETAILS INCLUDE HOW YOU OR YOUR PERSONAL REPRESENTATIVE MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice describes how **KNOLL CLINIC** and our health care providers, employees, volunteers, trainees and staff may use and disclose your medical information to carry out treatment, payment or health care operations and for other purposes that are described in this Notice. We understand that medical information about you and your health is personal, and we are committed to protecting medical information about you. This Notice applies to all records of your care generated by this practice and to substance use treatment-related records (SUD treatment records) under 42 U.S.C. §290dd-2 and 42 C.F.R. Part 2 (Part 2) that we receive or maintain. We also follow the confidentiality protections of Part 2 for such records. Certain uses and disclosures otherwise permitted by HIPAA are materially limited by Part 2.

This Notice also describes your right to access and control your medical information. This information about you includes demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services. We are required by law to protect the privacy of your medical information and to follow the terms of this Notice. We may change the terms of this Notice at any time. The new Notice will then be effective for all medical information that we maintain at that time and thereafter. We will provide you with any revised Notice if you request a revised copy be sent to you in the mail or if you ask for one when you are in the office.

I. Uses and Disclosures of Protected Health Information (“PHI”). Your medical information may be used and disclosed for purposes of treatment, payment and health care operations; provided, however, use or disclosure of SUD treatment records for payment and/or healthcare operations generally requires your written consent. The following are examples of different ways we use and disclose medical information. **These are examples only.**

(a) Treatment. We may use and disclose medical information about you to provide, coordinate, or manage your medical treatment or any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your medical information. For example, we could disclose your medical information to a home health agency that provides care to you. We may also disclose medical information to other health care providers who may be treating you, such as a health care provider to whom you have been referred to, to ensure that the health care provider has the necessary information to diagnose or treat you. In addition, we may disclose your medical information to another health care provider, such as a laboratory.

(b) Payment. We may use and disclose medical information about you to obtain payment for the treatment and services you receive from us. For example, we may need to provide your health insurance plan information about your treatment plan so that they can decide of eligibility or to obtain prior approval for planned treatment, such as disclosing relevant medical information to the health plan to obtain approval for hospital admission.

(c) Health_Care Operations. We may use or disclose medical information about you to support the business activities of our practice. These activities include, but are not limited to, reviewing our treatment of you, employee performance reviews, training of personnel, medical students, licensing, marketing and fundraising activities and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your health care provider. We can also call you by name in the waiting room when your health care provider is ready to see you. We may use or disclose your medical information to remind you of your next appointment. We may share your medical information with third party “business associates” that perform activities on our behalf, such as billing or transcription for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your medical information, we will have a written contract that contains terms that asks the “business associate” to protect the privacy of your medical information. We may use or disclose your medical information to provide you with information about treatment alternatives, case management or other health-related benefits and services that may be of interest to you. We may also use and disclose your medical information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, or a prescription refill reminder may be sent to you for a prescription you are currently prescribed or its generic equivalent. We may also send you information about products or services that we believe may be beneficial to you. You may contact our **Privacy Contact** to request that these materials not be sent to you. We may use or disclose your demographic information and the dates that you received treatment from your health care provider, as necessary, to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our **Privacy Contact** to request that these fundraising materials are not sent to you. If we intend to use or disclose records subject to 42 CFR part 2 for fundraising for the benefit of our practice, you will first be provided with a clear and conspicuous opportunity to elect not to receive any fundraising communications

(d) Health_Information Exchange. We, along with certain other health care providers and practice groups in the area, may participate in a health information exchange (“**Exchange**”). An Exchange facilitates electronic sharing and exchange of medical and other individually identifiable health information regarding patients among health care providers that participate in the Exchange. Through the Exchange, we may electronically disclose demographic, medical, billing and other health-related information about you to other health care providers that participate in the Exchange and request such information for purposes of facilitating or providing treatment, payment or health care operations.

II. Other Permitted and Required Uses and Disclosures That May Be Made with Your Consent, Authorization or Opportunity to Object.

We may use and disclose your medical information in the following instances. You can agree or object to the use or disclosure of all or part of your medical information. If you are not present or able to agree or object to the use or disclosure of the medical information, then your health care provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the medical information that is relevant to your health care will be disclosed.

(a) Others Involved in Your Health Care. Unless you object, we may disclose to a member of your family, a relative or close friend your medical information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information if we determine that it is in your best interest based on our professional judgment. We may use or disclose medical information to notify or assist in notifying a family member or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your medical information to an entity assisting in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

(b) Emergencies. We may use or disclose your medical information for emergency treatment. If this happens, we shall try to obtain your consent as soon as reasonable after the delivery of treatment. If the practice is required by law to treat you and has attempted to obtain your consent but is unable to do so, the practice may still use or disclose your medical information to treat you.

(c) Communication Barriers. We may use and disclose your medical information if the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and, in our professional judgment, you intended to consent to use or disclosure under the circumstances.

III. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object. We may use or disclose your medical information in the following situations without your consent or authorization. These situations include:

(a) Law Enforcement. We may use or disclose your medical information when federal, state or local law requires disclosure. You will be notified of any such uses or disclosure.

(b) Public Health. We may disclose your medical information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. This disclosure will be made for the purpose of controlling disease, injury or disability.

(c) Communicable Diseases. We may disclose your medical information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

(d) Health Oversight. We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. These activities are necessary for the government agencies to oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

(e) Abuse or Neglect. We may disclose your medical information to a public health authority that is authorized by law to receive reports of child / elder abuse or neglect. In addition, we may disclose your medical information to the governmental entity authorized to receive such information if we believe that you have been a victim of abuse, neglect or domestic violence as is consistent with the requirements of applicable federal and state laws.

(f) Food and Drug Administration. We may disclose your medical information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

(g) Legal Proceedings. We may disclose medical information during any judicial or administrative proceeding, when required by a court order or administrative tribunal, and in certain conditions in response to a subpoena, discovery request or other lawful process.

(h) Law Enforcement. We may disclose medical information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (i) responding to a court order, subpoena, warrant, summons or otherwise required by law; (ii) identifying or locating a suspect, fugitive, material witness or missing person; (iii) pertaining to victims of a crime; (iv) suspecting that death has occurred as a result of criminal conduct; (v) in the event that a crime occurs on the premises of the practice; and (vi) responding to a medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

(i) Coroners, Funeral Directors, and Organ Donors. (We may disclose medical information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose medical information to funeral directors as necessary to carry out their duties.

(j) Research. We may use and disclose your medical information for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board ("IRB") or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate, written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

(k) Criminal Activity. Consistent with applicable federal and state laws, we may disclose your medical information, if we 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. We may also disclose medical information if it is necessary for law enforcement authorities to identify or apprehend an individual.

(l) Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

(m) Military Activity and National Security. If you are a member of the armed forces, we may use or disclose medical information, (i) as required by military command authorities; (ii) for the purpose of determining by the Department of Veterans Affairs of your eligibility for benefits; or (iii) for foreign military personnel to the appropriate foreign military authority. We may also disclose your medical information to authorized federal officials for conducting national security and intelligence activities, including for the protective services to the President or others legally authorized.

(n) Workers' Compensation. We may disclose your medical information as authorized to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illness.

(o) Inmates. We may use or disclose your medical information if you are an inmate of a correctional facility and our practice created or received your health information while providing care to you.

(p) Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500, et seq.

(q) Imminent Threat to Health and Safety. As allowed by law, we may make disclosures of medical information if we believe you pose a risk to your own health and safety or the health and safety of another person.

IV. The Following Is a Statement of Your Rights with Respect to Your Medical Information and a Brief Description of How You May Exercise These Rights.

(a) You have the right to inspect and copy your medical information. This means you may inspect and obtain a copy of medical information about you that has originated in our practice. We may charge you a reasonable fee for copying and mailing records. To the extent we maintain any portion of your PHI in electronic format, you have the right to receive such PHI from us in an electronic format. We will charge no more than actual labor costs to provide you electronic versions of your PHI that we maintain in electronic format. After you have made a written request for our Privacy Contact at the address designated below, we will have thirty (30) days to satisfy your request. If we deny your request to inspect or copy your medical information, we will provide you with a written explanation of the denial. You may not have a right to inspect or copy psychotherapy notes. In some circumstances, you may have a right to have the decision to deny you access reviewed. Please contact **Privacy Contact** if you have any questions about access to your medical record.

(b) You have the right to request a restriction of your medical information. You may ask us not to use or disclose part of your medical information for the purposes of treatment, payment or health care operations. You may also request that part of your medical information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. You must state in writing the specific restriction requested and to whom you want the restriction to apply. You have the right to restrict information sent to your health plan or insurer for products or services that you paid for solely out-of-pocket and for which no claim was made to your health plan or insurer.

(c) We are not required to agree to your request. If we believe it is in your best interest to permit use and disclosure of your medical information, your medical information will not be restricted; provided, however, we must agree to your request to restrict disclosure of your medical information if: (i) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (ii) the information pertains solely to a health care item or service for which you (and not your health plan) have paid us in full. If we do agree to the requested restriction, we may not use or disclose your medical information in violation of that restriction unless it is needed to provide emergency treatment. Your written request must be specific as to what information you want to limit and to whom you want the limits to apply. The request should be sent, in writing, to our Privacy Contact.

(d) You have the right to request to receive confidential communications from us at a location other than your primary address. We will try to accommodate reasonable requests. Please make this request in writing to our Privacy Contact.

(e) You may have the right to have us amend your medical information. If you feel that medical information we have about you is incorrect or incomplete, you may request we amend the information. If you wish to request an amendment to your medical information, please contact our Privacy Contact. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us.

(f) You have the right to receive an accounting of disclosures we have made, if any, of your medical information. This applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice. It excludes disclosures we may have made to you, family members or friends involved in your care, or for notification purposes. To receive information regarding disclosures made for a specific time no longer than six (6) years and after April 14, 2003, please submit your request in writing to our Privacy Contact. We will notify you in writing of the cost involved in preparing this list. To the extent we maintain your PHI in electronic format, you may request an accounting of all electronic disclosures of your PHI for treatment, payment, or health care operations for the preceding three (3) years prior to such request.

(g) Uses and Disclosures of Protected Health Information Based upon Your Written Authorization. Other uses and disclosures of your medical information not covered by this Notice or required by law will be made only with your written authorization. For example, the following uses and disclosures require your authorization: (1) Most uses and disclosures of psychotherapy notes; (2) Uses and disclosures of PHI for

marketing purposes unless the communication (i) occurs face-to-face; (ii) consists of marketing gifts of nominal value; (iii) is regarding a prescription refill reminder that is for a prescription currently prescribed or a generic equivalent; (iv) is for treatment pertaining to existing condition(s) and we do not receive any financial remuneration in either cash or cash equivalent; and/or (v) communication from us to recommend or direct alternative treatments, therapies, health care providers or settings of care when we do not receive any financial remuneration for making the communication; and (3) Disclosures that constitute a sale of PHI and other than those described in this Notice, require authorization. You may revoke this authorization at any time, except to the extent that our practice has taken an action in reliance on the use or disclosure indicated in the prior authorization.

(h) Use of unsecure electronic communications. If you choose to communicate with us via unsecure electronic communications, such as regular email or text message, we may respond to you in the same manner in which the communication was received and to the same email address or account from which you sent your original communication.

In addition, if you provide your email address or cell phone number to a health care provider, we may send you emails or text messages related to appointment reminders, surveys, or other general informational communications. For your convenience, these messages may be sent unencrypted.

Before using or agreeing to use of any unsecure electronic communication to communicate with us, note that there are certain risks, such as interception by others, misaddressed/misdirected messages, shared accounts, messages forwarded to others, or messages stored on unsecured, portable electronic devices.

By choosing to correspond with us via unsecure electronic communication, you are acknowledging and agreeing to accept these risks. Additionally, you should understand that the use of email or other electronic communications is not intended to be a substitute for professional medical advice, diagnosis, or treatment.

(i) Right to be Notified of a Breach. You have the right to be notified if our practice (or a Business Associate of ours) discovers a breach of unsecured protected health information.

(j) Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated, as follows: U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>. You may file a complaint with us by notifying our Privacy Contact in writing. We will not retaliate against you for filing a complaint.

(k) Redisclosure: Information that is disclosed to third-parties pursuant to the HIPAA Privacy Rule is subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

IV. State Law. Applicable state law(s) may have certain requirements that govern the use or disclosure of your PHI. For us to release information about mental health treatment, genetic information, your AIDS/HIV status, alcohol or drug abuse treatment, or other specific medical information or conditions, you may be required to sign an authorization form unless state law allows us to make the specific type of use or disclosure without your authorization.

V. Applicability. This Notice and the obligations of Practice herein shall apply only to the extent that the information to be created, used and/or disclosed by Practice is PHI (as defined by HIPAA) and subject to HIPAA protections. By providing this Notice, Practice is neither conceding nor admitting that any such information qualifies as PHI.

VI. Substance Abuse Treatment. We are required to protect the privacy and security of your substance use disorder patient records in accordance with 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2, the Confidentiality of Substance Use Disorder Patient Records ("**Part 2**"), in addition to HIPAA and applicable state law. In a civil, criminal, administrative, or legislative proceeding against an individual, we will not use or share information about your SUD treatment records unless a court order requires us to do so (after notice and an opportunity to be heard is provided to you, as provided in 42 CFR part 2) or you give us your written permission. You may report suspected violations to the U.S. Attorney for the judicial district in which the violation occurs. Contact information for the U.S. Attorney office where we operate is below:

Ryan A. Kriegshauser
444 SE Quincy Street, Room 490
Topeka KS 66683

Suspected violations by an opioid treatment program may be reported to the Substance Use and Mental Health Services Administration (SAMHSA), Opioid Treatment Program Compliance Office by phone at 204-276-2700 or online at OTP-extranet@opiod.samhsa.gov.

Contact Information

Privacy Officer: Grady Knoll
Address: 1100 E 22nd Hays, KS 67601
Phone: 785-625-5500
Email: tknoll@knollclinic.com

Phone: 1-877-696-6775
Website: www.hhs.gov/ocr/privacy/hipaa/complaints/

To File a Complaint with HHS:
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201