NEW LIFE MEDICINE

Demographics

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ Phone (Cell): _____

DOB: _____ Age: _____ SSN: _____-_____-_____

Email: _____

Gender: _____ Marital Status: _____

Preferred Pharmacy Name: _____ Location: _____

*Referral Source/How did you hear about us? _____

Emergency Contact

Emergency Contact Name: _____

Relationship to patient: _____

Address: _____

Phone (Home): _____ Phone (Cell): _____

Insurance Information

Name of Primary Insurance: _____

Policy Holder Name: _____ DOB: _____

Subscriber ID #: _____ Group #: _____

Name of Secondary Insurance: _____

Policy Holder Name: _____ DOB: _____

Subscriber ID #: _____ Group #: _____

Current/Past Medical Conditions (check all that apply):

Please place and "F" by any Family History of Conditions.

General:

- ❑ Night Fever/Chills
- ❑ Change in appetite
- ❑ General Fatigue
- ❑ Frequent Nausea
- ❑ General Weakness
- ❑ Fibromyalgia

Integumentary:

- ❑ Skin Rash
- ❑ Changes in skin appearance
- ❑ Hair Changes
- ❑ Skin Cancer
- ❑ Easy Bruising
- ❑ Abscess

Head/Ears/Eyes/Nose/Throat:

- ❑ Bad Teeth
- ❑ Mouth Sores
- ❑ Nasal Discharge
- ❑ Hearing Loss
- ❑ Change in Vision
- ❑ Blindness
- ❑ Gum Disease
- ❑ Sore Throat
- ❑ Sinusitis
- ❑ Ear Drainage
- ❑ Eye Discharge
- ❑ Glaucoma

Cardiovascular:

- ❑ Infection in your heart (Endocarditis)
- ❑ Cardiac Arrest
- ❑ Heart Failure (CHF)
- ❑ Heart Murmur
- ❑ Arrythmia
- ❑ Heart Attack (MI)
- ❑ High Blood Pressure
- ❑ Palpitations
- ❑ Chest Pain (Angina)
- ❑ Rheumatic Fever

Respiratory:

- ❑ Bronchitis
- ❑ Emphysema
- ❑ Shortness of breath
- ❑ Lung Cancer
- ❑ Asthma
- ❑ Wheezing
- ❑ Tuberculosis
- ❑ COPD
- ❑ Pneumonia
- ❑ Chronic Cough

Nervous System:

- ❑ Anxiety Disorder
- ❑ Bad Nerves
- ❑ Tension Headaches
- ❑ Blackout Spells
- ❑ Paralysis
- ❑ Spinal Cord Disease
- ❑ Depression
- ❑ Chronic Headaches
- ❑ Brain Disease
- ❑ Numbness
- ❑ Alzheimer's
- ❑ Epilepsy
- ❑ Insomnia
- ❑ Migraines
- ❑ Fainting
- ❑ Weakness
- ❑ Meningitis
- ❑ Seizures

Gastrointestinal:

- ❑ Hepatitis
- ❑ Ulcers
- ❑ Constipation
- ❑ Irritable Bowel
- ❑ Gallbladder Disease
- ❑ Liver Disease
- ❑ Hernia
- ❑ Diarrhea
- ❑ Chrohn's Disease
- ❑ Loss of bowel control
- ❑ Jaundice
- ❑ Reflux
- ❑ Blood in stools
- ❑ Ulcerative Colitis

Endocrine:

- ❑ Type I Diabetes
- ❑ Thyroid Disease, high
- ❑ Type II Diabetes
- ❑ Thyroid Disease, low
- ❑ Pancreatitis

Musculoskeletal:

- ❑ Arthritis
- ❑ Bursitis
- ❑ Rheumatoid Arthritis
- ❑ Artificial Joints
- ❑ Osteomyelitis (Infection in the bone)
- ❑ Osteoporosis (Low bone density)

Genito-Urinary:

- ❑ Kidney Stones
- ❑ Loss of control
- ❑ Low Kidney Function
- ❑ Kidney Infection
- ❑ Loss of control of urine
- ❑ Dialysis
- ❑ Bladder Infection
- ❑ Kidney Failure

Hematology:

- ❑ Taking Blood Thinners
- ❑ Easy Bleeding
- ❑ Anemia
- ❑ Hemophilia
- ❑ Sickle Cell Trait
- ❑ Blood Clots
- ❑ Easy Bruising
- ❑ Abnormal Clotting
- ❑ Swollen Glands or Lymph Nodes
- ❑ Sickle Cell Disease

Other Medical Problems:

1.	2.
3.	4.

Family History:

If there is any family history of the illnesses listed (Page 2-3), please put an "F" next to that illness.

Is there a family history of anything NOT listed? Please explain:

_____

Surgical History:

Please include dates, where possible.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Childhood Illnesses:

Measles: Y ❑ or N ❑ Mumps: Y ❑ or N ❑ Chicken Pox: Y ❑ or N ❑

Medication Allergies:

Please indicate the drugs that you are allergic to and what happens when you take it.

Drug Name	Side Effects/Reactions
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Please indicate any other allergies you may have:

❑ Bee stings ❑ Hay fever ❑ Pollen ❑ Grass ❑ Dogs ❑ Cats

Other: _____

Current Medications:

Please list all medications that you are **prescribed**, dosage, and how often you take it.

	Medication	Dose	How often taken
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Social History:

Cigarettes: Now? ❑ Yes ❑ No In the past? ❑ Yes ❑ No

How many per day on average? _____ For how many years? _____

Alcohol: Now? ❑ Yes ❑ No In the past? ❑ Yes ❑ No

How much per day on average? _____ For how many years? _____

Other Providers:

Please list other providers that treat you. List their name, specialty, and phone/fax numbers.

1. _____
2. _____
3. _____
4. _____
5. _____

Psychiatry:

Have you ever been diagnosed with a psychiatric or mental illness? ❑ Yes ❑ No

❑ Antisocial	❑ Schizophrenia	❑ PTSD
❑ Depression	❑ Bipolar	❑ Anxiety

Past Mental Health Medications

If you have taken any of the following for mental health please check and fill in information

	Medication	Dose	Response Effect
☐	Medication		
☐	Airpazolam (Xanax		
☐	Amitriptyline (Eavil)		
☐	Aripiprazole (Abilify)		
☐	Brexiprazole (Rexulti)		
☐	Bupropion (Wellbutrin		
☐	Buspirone (Buspar)		
☐	Cariprazinhe (Vraylar)		
☐	Citalopram (celxa)		
☐	Clonazepam (Klonopin)		
☐	Clonidine		
☐	Clozapine (Clozaril)		
☐	Desvenlafaxine (Pristiq)		
☐	Diazepam (Valium)		
☐	Doxepin (Silenor)		
☐	Duloxetine (Cymbalta)		
☐	Escitalopram (Lexapro)		
☐	Exzopiclone (Lunesta)		
☐	Fluoxetine (Prozac)		
☐	Fluoxamine (Luvox)		
☐	Gabapentin (Neurontin)		
☐	Haloperidol (Haldol)		
☐	Hydroxyzine (Vistril)		
☐	Lamotrigine (Lamictal)		

	Medication	Dose	Response Effect
☐	Lithium		
☐	Lorazepam (Ativan)		
☐	Mirtazapine (Remeron)		
☐	Nortriptyline (Pamelor)		
☐	Olanzapine (Zyprexa)		
☐	Paliperidone (Invega)		
☐	Paroxetine (Paxil)		
☐	Prazosin (Minipress)		
☐	Quetiapine (Seroquel)		
☐	Risperidone (Risperdal)		
☐	Sertraline (Zoloft)		
☐	Temazepam (Restoril)		
☐	Topirimate (Topomax)		
☐	Valproic acid (Depakote)		
☐	Venlafaxine (Effexor)		
☐	Vilazodone (Viibyrd)		
☐	Ziprasidone (Geodon		
☐	Zolpidem (Ambien)		
☐	Oxcarbazepine (Trileptal)		
☐	Methadone		
☐	Naltrexone/Vivitrol		
☐	Buprenorphine		
☐	(Subutex, Suboxone		

NEW LIFE MEDICINE

CONSENT FOR CARE AND TREATMENT

I voluntarily consent to receive medical care, treatment, and services provided by New Life Medicine, including but not limited to primary care services, diagnostic procedures, examinations, laboratory testing, and preventive care.

I understand that:

- My care may include evaluation, diagnosis, and treatment by physicians, nurse practitioners, physician assistants, nurses, and other clinical staff.
- Medical care may involve procedures such as physical exams, blood draws, injections, immunizations, diagnostic testing, and other routine medical services.
- The practice of medicine is not an exact science, and no guarantees or assurances have been made to me regarding the results of my care or treatment.

TELEHEALTH CONSENT

I consent to receive healthcare services via telehealth when appropriate.

I understand that:

- Telehealth may involve the use of electronic communications to enable providers to diagnose, treat, and follow up on my condition.
- There are potential risks including interruptions, unauthorized access, or technical difficulties.
- I have the right to refuse telehealth services at any time.

FINANCIAL RESPONSIBILITY

I understand that:

- I am responsible for all charges related to my care, including copayments, deductibles, coinsurance, and any non-covered services.
- My insurance coverage is a contract between me and my insurance company.
- I authorize New Life Medicine to bill my insurance on my behalf and to release necessary information for claims processing.
- I agree to provide updated insurance and billing information as needed.

RELEASE OF INFORMATION

I authorize New Life Medicine to:

- Use and disclose my health information for purposes of treatment, payment, and healthcare operations.
- Share information as required by law or for public health reporting.

PATIENT RIGHTS

I acknowledge that:

- I have received or have access to the Notice of Privacy Practices.
- I have the right to ask questions about my care and treatment.
- I may withdraw this consent at any time in writing, except to the extent that action has already been taken.

ACKNOWLEDGMENT

By signing below, I confirm that:

- I have read and understand this consent form.
- I have had the opportunity to ask questions and receive answers.
- I voluntarily consent to care and treatment at New Life Medicine.

Patient Signature: _____ Date: _____

NEW LIFE MEDICINE

ASSIGNMENT OF BENEFITS/RELEASE OF MEDICAL INFORMATION

I hereby authorize and request that payment of benefits by my Insurance Company(s) be made directly to New Life Medicine herein referred to as "Facility", for services furnished to me or my dependent. I understand that my Insurance Company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

In addition, I authorize the facility to disclose all written information from the above named to my Insurance Company(s) or its designated representatives, or other financially responsible party, at the determination of facility. Such disclosure shall be for reimbursement purposes for those services received.

I hereby release the facility, its officers, agents, employees, and any clinician associated with my case, from all liability that may arise because of disclosure of information to my Insurance Company(s) or their designated representatives.

By signing this Assignment of Benefits and Release of Information, I acknowledge:

- I am aware and understand that this authorization will not be used unless my Insurance Company(s) or their designated representatives request records of information for reimbursement purpose; or seek to act on reference payment for treatment services.
- I agree to participate in and assist the Facility and its designated representatives with the appeal process necessary to collect payment for the services rendered.
- I am aware and have been advised of the provisions of Federal and State Statutes rules and regulations that provide for my right to confidentiality to these records.
- I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
- The facility is acting in filing insurance benefits assigned to New Life Medicine and it can assume no responsibility for guaranteeing payments of any charges from the Insurance Company(s).
- Billing may be done by a firm contracted by Facility for billing and collection purposes.
- Facility has been appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment for my insurance carrier.
- Should an overpayment take place, a refund check will be mailed to the authorized party that is owed the overpayment.
- The facility shall be entitled to the full amount of its charges without offset.
- I agree to endorse and forward to Facility any monies from the Insurance Company(s) paid to me and/or the primary insurance. I understand that I am otherwise responsible for the cost of all charges accrued.

Signature: _____ Date: _____

NEW LIFE MEDICINE

CLIENT FEE SCHEDULE & FINANCIAL RESPONSIBILITY

New Life Medicine believes that a key component of quality healthcare is the clear establishment and communication of our financial policy to patients. We are committed to delivering the highest quality care and ensuring that you have a clear and complete understanding of our financial policy.

Fee information for those without insurance coverage:

OBOT Services (all OBOT patient visit fees include physician and counseling services, drug screens, assessments, case management, and basic labs (CBC, CMP, HIV, & Hepatitis C):

- **Weekly Patients: $50**
- **Bi-Weekly Patients: $100**
- **Monthly Patients: $200**

Additional Services:

- **Primary Care & MAT Services Provided Same-Day: OBOT Fee + $25 PCP Visit Fee**
- **Primary Care (Non-OBOT Patients): $150 Initial Visit; $50 Follow-Up**
- **Individual Counseling (Non-OBOT Patients): $100 per visit**
- **Department of Transportation (DOT) Physical: $95**

**DOT Physicals are non-billable to medical insurance*

NLM offers a sliding scale based on the patient's income. Please speak to the front staff if you are interested in applying for the sliding scale.

Payment Policy: Payment is expected at the time of your visit, at check-in, before services are rendered. We will accept cash (**ONLY** for co-payments) or credit card (with fee). Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company including maximum out of pocket benefit limits. **If you do not carry insurance, or if your coverage is currently pended due to your non-payment of premium, payment in full is expected at the time of your visit**. If you are unable to pay at the time of your visit, your appointment will be rescheduled for the next available date. If you have any questions regarding charges or billing, please contact our office. New Life Medicine does not receive governmental or other funding or donations applicable to the fee or fees for services.

Insurance: We will file the appropriate insurance claims on your behalf. Please remember that insurance is a contract between the client/patient and the insurance company and ultimately the client/patient is responsible for payment in full. If your insurance company does not render payment to the practice within a reasonable period (60 days), you may be billed for services provided. If we later receive payment from your insurer, we will refund any overpayment to you. Refunds are given on a case-by-case basis. If we are out-of-network providers, you may be responsible for partial or full payment depending upon your insurance policy. Due to the many different insurance products, our staff cannot guarantee your eligibility

and coverage at the time you are seen. Be sure to verify your coverage details with your insurer's member benefits department before your appointment. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you may be responsible for payment in full for all services provided.

Your insurance may be billed for ancillary services which include but are not limited to laboratory testing, urine drug screens, group meetings, individual counseling sessions, case management sessions, chronic care management, etc. You will be required to pay all patient-responsible cost-shares associated with these services according to your insurance plan.

General Consent for Treatment and Financial Responsibility:
I hereby authorize New Life Medicine and its healthcare providers to provide medical care and treatment as deemed necessary. I understand that I am financially responsible for all charges for services rendered, including those not covered or paid by my insurance plan. This includes, but is not limited to, co-payments, deductibles, co-insurance, and services deemed non-covered or not medically necessary by my insurance.

I authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of medical benefits to New Life Medicine for services rendered. I understand it is my responsibility to notify the clinic of any changes to my insurance coverage or contact information.

By signing below, I acknowledge that I have read, understand, and agree to the terms of this financial policy and give general consent for treatment.

Patient Name: _____

Patient Signature: _____ Date: _____

NEW LIFE MEDICINE

CONSENT FOR LABORATORY DRUG SCREENING

It is the policy of New Life Medicine to provide each client with an alcohol and illicit drug free environment. Urine drug screens and breathalyzer tests will help us in achieving our goal.

As a client of New Life Medicine, I understand that I will be expected to submit urine and/or oral samples for drug and/or alcohol screenings under the supervision of staff.

I understand that I may be requested to provide a urine and/or oral sample upon admission, for scheduled and/or randomly, or upon suspicion of drug or alcohol abuse.

My signature below indicates that I have acknowledged New Life Medicine's drug free protocols and consent to the administration of urine and/or oral drug screening by staff of New Life Medicine.

I understand that my refusal to provide a urine and/or oral specimen upon request could result in my being asked to leave New Life Medicine and to forfeit all my rights and privileges as a client.

Patient Name: _____

Patient Signature: _____ Date: _____

NEW LIFE MEDICINE

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.

Effective Date: January 1, 2017
Revised Date: January 14, 2026

We understand that your health information is personal, and we are committed to protecting its privacy. We are required by law to:

- Maintain the privacy of your health information.
- Give you this notice of our legal duties and privacy practices regarding your health information.
- Follow the terms of our Notice of Privacy Practices that are currently in effect; and
- Notify you following a breach of your unsecured health information

Your rights regarding health information about you

Right to inspect and copy: You have the right to request to inspect and obtain a paper or electronic copy of the health information that may be used to make decisions about your care or payment, and to request that an electronic copy of your electronic health record be forwarded to a third party of your choice. However, under certain circumstances and, if permitted by law, we may deny your request. To inspect and obtain a copy of your health information, you must submit your request in writing. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request, or less as required by state law. There may be reasonable, cost-based fees for the costs of copying, mailing or other supplies associated with your request.

Right to amend: If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend the information as long as it is kept by New Life Medicine. To request an amendment, your request must be made in writing and provide a reason that supports your request. Ask us how to submit this request. We may deny your request under certain circumstances. You will be informed of the decision regarding any request for amendment of your health information within 60 days and, if we deny your request for amendment, we will provide you with information regarding your right to respond to that decision.

Right to an accounting of disclosures: You have the right to request a list of certain disclosures we make of your health information. We will include all disclosures except those for treatment, payment, health care operations, and certain other disclosures (such as those you asked us to make). To request this list of disclosures, you must submit your request in writing to us. Your request must state a time period for which the accounting of disclosures is sought, which cannot be longer than six years prior to the date on which your request for accounting is made. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list but will notify you of the cost involved and offer you the chance to withdraw or modify your request before any costs are incurred.

Right to request restrictions: You have the right to request a restriction on the health information we use or disclose about you for treatment, payment, health care operations, to persons involved in your care or payment, or disclosures for disaster relief purposes. We are not required to agree to a request for restrictions, other than a request that we not disclose information to a health plan for payment or health care operations where the request relates only to a health care item or service for which we have been paid in full. We will notify you if we don't agree to your request for restriction. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to us. 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 health plan.

Confidential communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. Your request

must be in writing and specify how or where you wish to be contacted and to what address we may send bills for payment for services provided to you. We will accommodate reasonable requests.

Right to a paper copy of this notice: You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may also obtain a copy of this notice at our website www.newlifemedicinegroup.com.

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 reasonable efforts to ensure the person has this authority and can act for you before we take any action.

How your health information may be used and disclosed without your authorization: The following describes different ways that we are permitted to use and disclose health information that identifies you. If you receive services at any of our facilities, then information that identifies that you have or had a substance use disorder (Substance Use Disorder Records) are subject to additional restrictions that are addressed below. Note that the federal medical privacy law commonly known as HIPAA only applies to certain entities (certain health care providers, health plans, and entities acting on their behalf). Accordingly, health information that is disclosed as described below in accordance with HIPAA may be subject to redisclosure by the recipient and no longer protected by HIPAA. For example, if we disclose your health information as required by a court order, the information may no longer be protected by HIPAA.

Treatment: We may use health information to treat you or provide you with healthcare services. For example, we may tell your primary care physician about the care we provided you or give health information to a specialist to provide you with additional services. We generally will not disclose Substance Use Disorder Records for treatment purposes without your consent, except in a bona fide medical emergency in which your consent cannot be obtained.

Payment: We may use and disclose health information so that we may bill or receive payment from you, an insurance company, or a third party for the treatment and services provided to you. For example, we may disclose your health information to your insurance company in order to receive payment for service rendered. We generally will not disclose Substance Use Disorder Records for payment purposes without your consent.

Healthcare operations: We may use and disclose health information for healthcare operations and administrative purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may share information with doctors, nurses, medical students, and other personnel for learning purposes. We generally will not disclose Substance Use Disorder Records for health care operations purposes without your consent.

Individuals involved in your care or payment for your care: If you do not object, or we reasonably infer, based on professional judgment, that you do not object to the disclosure, we may disclose relevant health information to a family member, friend, or other person involved in your medical care or who helps pay for your care. We may also disclose health information to a personal representative, who is a person who has legal authority to make healthcare decisions on your behalf. We generally will not disclose Substance Use Disorder Records to a family member, friend, or other person involved in your medical care or payment without your consent.

Business associates: We may disclose health information to our business associates who perform functions on our behalf or provide us with services, if the information is necessary for such functions or services.

Research: Under certain circumstances, we may use and disclose health information for research purposes provided that we comply with applicable federal and state legal requirements.

Other purposes: We may use or disclose health information about you for other reasons:

- In a disaster relief situation (except for Substance Use Disorder Records).

- When required by international, federal, state or local law, including a request by the Secretary of the Department of Health and Human Services to see that we are complying with federal privacy law (additional restrictions may apply to disclosures of Substance Use Disorder Records).
- To avert or reduce a serious threat to health or safety of the public or another person (except for Substance Use Disorder Records).
- For special government functions such as national security and intelligence activities, including presidential protective services (except for Substance Use Disorder Records).
- For a member of the Armed Forces (domestic or foreign), we may disclose your medical information as required by military command authorities (except for Substance Use Disorder Records).
- In response to a court or administrative order, subpoena or other lawful process (except that a specialized type of court order generally is required before we will disclose Substance Use Disorder Records).
- To a law enforcement official for law enforcement purposes provided we comply with applicable legal restrictions (except for Substance Use Disorder Records).
- To report suspected abuse, neglect, or domestic violence.
- If you are an inmate, to the correctional institution or law enforcement official (except for Substance Use Disorder Records).
- To an organ donation bank or to facilitate organ or tissue donation and transplantation (except for Substance Use Disorder Records).
- To workers' compensation or similar programs for work-related injuries or illness to the extent necessary to comply with laws related to these programs (except for Substance Use Disorder Records).
- For public health activities such as to prevent or control disease, injury or disability; to report births and deaths; to notify a person who may have been exposed or who may be at risk of spreading a disease; or reporting information to the Food and Drug Administration (FDA) if you experience an adverse reaction from any drugs, supplies or equipment (except for Substance Use Disorder Records).
- To health oversight agencies for activities authorized by law (except for Substance Use Disorder Records).
- To a coroner/medical examiner as authorized by law to identify a deceased person or determine cause of death (except for Substance Use Disorder Records).
- To funeral directors to carry out their duties (except for Substance Use Disorder Records).

Uses and disclosures of medical information which require your authorization: Uses and disclosures of health information that are not discussed by this notice or required by law will only be made with your written permission. Your written authorization will typically be required for most uses and disclosures of psychotherapy notes, most uses and disclosures for marketing and most arrangements involving the sale of health information.

Further restrictions on substance use disorder records: We generally will not use or disclose substance use disorder treatment records received from programs that hold themselves out as providing substance use disorder services (including programs outside of New Life Medicine) in civil, criminal, administrative, or legislative proceedings against you without your consent or a special type of court order that is specific to substance use disorder records and is accompanied by a subpoena or other legal requirement compelling disclosure.

How you may revoke your authorization: If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. Your request to revoke your authorization must be sent to our Compliance Officer.

Changes to this notice: We reserve the right to change this notice and the revised or changed notice will be effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at our facilities and on our website. You may request a copy of the new notice be sent to you in the mail or electronically.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact our Compliance Officer at 423-434-6677. There will be no retaliation against you for filing a complaint.

Contact: If you have questions or would like additional information, you may contact the Compliance Officer at 423-434-6677 or via the Contact Us form on our website.

Confidentiality of substance use disorder patient records: New Life Medicine specializes in providing substance use disorder treatment. Federal law and regulations provide additional privacy protection to information about substance use disorder treatment generated by these programs. Accordingly, in addition to the privacy protections described in the New Life Medicine Notice of Privacy Practices, these additional restrictions apply to substance use disorder treatment records generated by programs. These restrictions do not apply to substance use disorder information that is not generated by a program, such as substance use disorder information generated by a primary care physician.

Generally, the programs may not identify that you receive services at a program, or disclose any information from a program identifying you as receiving substance use disorder treatment (collectively, "Substance Use Disorder Records") unless:

1. You consent in writing;
2. The disclosure is allowed by a court order specific to Substance Use Disorder Records; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

The programs must obtain your consent for most uses and disclosures of your Substance Use Disorder Records for treatment, payment, or health care operations. For example, the programs must obtain your consent to disclose your Substance Use Disorder Records to your primary care physician. You may provide a single consent for all future uses or disclosures of your Substance Use Disorder Records for treatment, payment, and health care operations purposes (TPO Consent Form). The programs may only make uses and disclosures of your Substance Use Disorder Records that are not listed in this notice with your written consent. You may revoke a consent in writing at any time, except to the extent that the program or a recipient of your substance use disorder has already acted in reliance on your consent. Your request to revoke your consent must be sent to our Compliance Officer.

Substance Use Disorder Records, or testimony relaying the content of such records, may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless based on written consent, or a court order after notice and an opportunity to be heard is provided to you or the holder of the record, as provided in the federal law governing confidentiality of substance use disorder records at 42 C.F.R. part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Substance Use Disorder Records that are disclosed to another program governed by 42 C.F.R. part 2 or to a HIPAA covered entity or business associate pursuant to your written consent for treatment, payment, and health care operations may be further disclosed by the recipient (including New Life Medicine), without your written consent, to the extent HIPAA regulations permit such a disclosure.

Federal law and regulations governing Substance Use Disorder Records do not protect:

- Any information about a crime committed by a patient either at the treatment program or against any person who works for the program, or about any threat to commit such a crime.
- Any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

Your rights regarding your substance use disorder treatment records: You have the following rights with respect to your substance use disorder treatment records:

- The right to request restrictions on disclosures made with your prior consent for purposes of treatment, payment, and health care operations.
- The right to request and obtain restrictions of disclosures of Substance Use Disorder Records to your health plan for those services for which you have paid in full.
- To the extent that your Substance Use Disorder Records are disclosed to an intermediary, such as a Health Information Exchange network, for further disclosure, you have a right to a list of disclosures by the intermediary for the past three years.
- You have a right to obtain a paper or electronic copy of this notice upon request.
- You have a right to discuss this notice with the Compliance Officer.

For information about the programs' duties with respect to privacy, how to file a complaint regarding a program, and contact information for further information about this notice, please see the sections of the New Life Medicine Notice of Privacy Practices titled "Complaints," and "Contact."

Changes to This Notice: We reserve the right to change this notice and the revised or changed notice will be effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at our facilities and on our website. You may request a copy of the new notice be sent to you in the mail or electronically.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact our Compliance Officer at 423-434-6677. There will be no retaliation against you for filing a complaint.

Contact: If you have questions or would like additional information, you may contact the Compliance Officer at 423-434-6677 or via the Contact Us form on our website.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of New Life Medicine's **Notice of Privacy Practices**, which explains how my health information may be used and disclosed and how I can access my information. I understand that I may request a copy of this Notice at any time.

I understand that this Notice applies to my protected health information, including any records that may be subject to additional protections under **42 CFR Part 2**, when applicable.

Signature: _____ Date: _____

PATIENT COMMUNICATION CONSENT

New Life Medicine
2408 Susannah Street
Johnson City, TN 37601
P: (423) 434-6677
F: (423) 461-0000

We may need to contact you regarding your medical care. This is to acknowledge that you authorize New Life Medicine to:

- Leave a detailed message on cell phone or home phone voicemail/machine.
- Call my workplace phone number and leave a message.
- None of the above

A federal law was passed in 2014 and became effective on September 30, 2014, governing how we may contact you via telephone, text, and email. Listed below are some of the reasons we may need to contact you via telephone, text, or email:

- Appointment reminders
- Cancel or change an appointment.
- Reminder calls about annual preventive care due.
- Medication reminders

By providing a telephone number, I expressly consent and authorize the physician practice, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message.

I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods, and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act 15 U.S.

Code § 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting the Provider or utilizing the opt-out method that will be identified in the applicable communication.

I have read and understand the above and consent to contact as described.

Signature: _____ Date: _____