Peaceful Balance
Health & Wellness Services, LLC
Lorraine W. Bock, DNP, CRNP

9 East High St.-Rear
Carlisle, PA 17015

Ph: (717)440-0498
Fax: (717)918-5784

# Patient History

Patient Name:_____ DOB:_____

Medical History (Please attach a list of all medications with dosage/frequency)

| Diagnosis | Date of Diagnosis | Treatment |
|---|---|---|
| ☐ Depression | | |
| ☐ Asthma | | |
| ☐ COPD/Emphysema | | |
| ☐ Anemia | | |
| ☐ Hypertension | | |
| ☐ High Cholesterol | | |
| ☐ Diabetes | | |
| ☐ Stroke | | |
| ☐ Heart Attack | | |
| ☐ Kidney Disease | | |
| ☐ Rheumatic Fever | | |
| ☐ Traumatic Brain Injury | | |
| ☐ Osteoarthritis | | |
| ☐ Rheumatoid Arthritis | | |
| ☐ GI Issues | | |
| ☐ Congestive Heart Failure | | |
| ☐ Vascular Disease | | |
| ☐ Liver Disease | | |
| ☐ Thyroid Disorder | | |
| ☐ Seizure Disorder | | |
| ☐ Eczema | | |
| ☐ Headaches | | |
| ☐ Kidney Stones | | |
| ☐ Prostate Disease | | |

Women's Health

Pregnancies 0 1 2 3 4 ____
Live Births ____ Miscarriages_____
Abortions____
First day of last period_____ Last Pap_____
Are your periods regular? ☐ Y ☐ N
Last mammogram_____
Last Dexscan_____

Men's Health

Date of Last Prostate Exam:_____

Sexual Status:
☐ Heterosexual ☐ Homosexual
☐ Bisexual ☐ Transexual
Are you sexually active? ☐ Y ☐ N

Marital Status:
☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

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Previous Illnesses (Including Cancer, Hospitalizations, Etc.):

Previous Surgeries:

Allergies (foods, medications, insects) and reactions:

Other Medical Diagnoses:

Specialty Exam

Last Colonoscopy_____
Last FIT Kit test_____
One time Hepatitis C screening (for people with birth year 1945-1965) ☐Y ☐N ☐N/A_____

Annual Lung Cancer Low-contrast CT screening (for ages 55-80 with a 30 pk/year history and Currently smoke or have quit within last 15 yrs)
☐ Y ☐ N Date_____

Family History

Number of children___Boy(s) ages_____
Girl(s) ages_____

Siblings:_____ Brother(s) ages _____
Sister(s) ages_____

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Family History (please circle family member that apply)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Auto-immune Disease** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| **Specify_____** | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |
| **Bipolar** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |
| **Depression** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |
| **Diabetes** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |
| **Stroke/TIA** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |
| **Blood Clots** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |
| **Heart Attacks,** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| **Stents/Bypass** | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |
| **Atrial Fibrillation** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| **(A-fib)** | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |
| **Lung Cancer** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |
| **Pancreatic Cancer** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |
| **Colon Cancer** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |
| **Prostate Cancer** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |
| **Breast Cancer** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |
| **Ovarian Cancer** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |
| **Uterine Cancer** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |
| **Melanoma** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |
| **Sickle Cell** | Mother | Father | Brother1 | Brother2 | Sister1 | Sister2 | Aunt | Uncle |
| | Maternal Grandmother | | Maternal Grandfather | | Paternal Grandfather | | Paternal Grandmother | |

Other Family History (list all immediate (mother, father, sister, brother) family members that are deceased, age at death and cause of death)

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# Social History

**Diet**

☐ No dietary restrictions
☐ Low Fat ☐ Low Cholesterol ☐ Low Carb
☐ Vegetarian ☐ Commercial Food Plan_____
☐ Other restrictions_____

Caffeine
☐ Yes Type_____servings/day_____
☐ No (including chocolate and energy drinks.

**Exercise**
☐ None
☐ I exercise____times/week for___hrs total/week
Types of Exercise: ☐ walking ☐ biking ☐ aerobic
☐ swim ☐ strength training ☐ jogging/running
☐ yoga ☐ other_____

**Living Situation**
☐ I live alone
☐ I live in a home with the following people:_____
_____
I live in: ☐ Single Family Home ☐ Apartment
☐ temporary housing ☐ I am homeless

**Ethnicity**
☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline

**Race**
☐ Caucasian ☐ African American ☐ American Indian
☐ Asian ☐ Decline

**Tobacco Use**

☐ Never
☐ Currently smoke____pk/day for_____yrs
☐ Used to smoke____pk/day for____yrs
Stopped smoking_____mo/yrs ago
☐ Currently use_____tobacco product and consume____per day for _____yrs.
☐ I used to use_____tobacco product for _____yrs. Stopped ____mo/yrs ago.

**Alcohol**
☐ Never
I used to drink but no longer drink. I would consider myse3lf a ☐ recovering alcoholic
☐ social drinker/no longer drinking
I drink ____servings of beer/wine/hard (circle one) liquor.
I drink ☐ daily ☐ weekly ☐ monthly

**Recreational Drug Use**
☐ Never
I have used the following:

| | | |
|---|---|---|
| Marijuana | ☐ in the past | ☐ presently |
| Cocaine | ☐ in the past | ☐ presently |
| Heroin | ☐ in the past | ☐ presently |
| Amphetamine | ☐ in the past | ☐ presently |
| LSD | ☐ in the past | ☐ presently |
| PCP | ☐ in the past | ☐ presently |
| Prescription | ☐ in the past | ☐ presently |

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# Recent Health

**General**
☐ Feeling well ☐ Chills ☐ Fever ☐ Recent weight gain/loss
☐ Fatigue ☐ Sweats ☐ Pregnancy

Comments:

_____

_____

**Skin**
☐ Rashes ☐ Sores ☐ Excessive skin dryness ☐ Other_____

**Head**
☐ Dizziness ☐ Headaches ☐ Hearing ☐ Vision ☐ Sinus ☐ Seizures ☐ Other_____

**Lungs**
☐ Shortness of breath at night ☐ Shortness of breath lying down ☐ Shortness of breath with exercise
☐ Wheezing ☐ Cough

**Heart**
☐ Chest pain ☐ Chest pressure ☐ Palpitations ☐ Hear Murmur ☐ Fainting/syncope ☐ Swollen extremities

**Gastrointestinal**
☐ Bleeding ☐ Loss of appetite ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Indigestion ☐ Abdominal pain

**Genitourinary**
☐ Burning w/urination ☐ Frequent urination ☐ Discharge ☐ Incontinence ☐ Reduced Stream ☐ Blood in urine

**Extremities**
☐ Joint Swelling ☐ Difficulty walking ☐ Arthritis ☐ Joint Pain (location)_____ ☐ Joint Trauma

**Neurological**
☐ coordination difficulty ☐ Dizziness ☐ Memory ☐ Fainting ☐ Numbness

**Psychiatric**
☐ Anxiety ☐ Depression ☐ Insomnia ☐ Hallucinations

Additional Concerns: _____

_____

_____

_____

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# Insurance Authorization

**Patient's Information:**

Name: _____ Date of Birth: _____ Sex: ☐Male ☐Female

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

**Insurance Information:**

| | | | |
|---|---|---|---|
| **Primary** Insurance Company Name | Name of Policy Holder | Policy/ID Number | Group Number |
| **Secondary** Insurance Company Name | Name of Policy Holder | Policy/ID Number | Group Number |

How did you hear about our practice? _____

**Authorization to treat:**

I hearby authorize providers associated with Coastal Primary Care to complete all assessment, diagnosis and treatment for medical conditions

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:**

I hereby authorize payment directly from my insurance company to the provider of Coastal Primary Care PLLC for medical treatment(s) provided to me or my Child
I understand that payment in full of my responsible portion is required at the time of visit. If Coastal Primary Care is not a provider on my insurance, full payment is due on the date of service. If Coastal Primary Care is a provider on my insurance, then any deductibles, co-pays, or percentages are due at the time of service. Additionally, should at be necessary to assign my account for collections, it is hereby agreed that I shall pay reasonable charges, attorney's fees and all other costs.
I hereby authorize Coastal Primary Care to examine and treat me or my Child when necessary. I also authorize the release of my protected health information, acquired in the course of examination to carry out treatment, payment and healthcare operations of me or my Child.

**FINANCIAL/OFFICE POLICY & HIPAA:**

I have read and understand the foregoing financial and office policy and agree to abide by the terms of this policy. I also acknowledge that I have received a copy of the Notice of Privacy Practices, including Omnibus Rule

_____ _____
**Patient/Representative Signature** Date

If the patient listed above is a minor or unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____
**Print name** **Relationship to patient**

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# OMNIBUS Rule
## HIPAA 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 UNDER THE HIPAA OMNIBUS RULE OF 2013. PLEASE REVIEW CAREFULLY.**

For purposes of this Notice "us" "we" and "our" refers to the Name of this Healthcare Clinic: Peaceful Balance Health & Wellness Services, LLC and "you" or "your" refers to our patients (or their legal representatives as determined by us in accordance with state informed consent law). We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so.

The Federal Health Insurance Portability & Accountability Act of 2013, HIPAA Omnibus Rule, (formally HIPAA 1996 & Hi Tech of 2004) require us to maintain the confidentiality of all your healthcare records and other identifiable patient health information (PHI) used by or disclosed to us in any form, whether electronic, on paper, or spoken. HIPAA is a Federal Law that gives you significant new rights to understand and control how your health information is used. Federal HIPAA Omnibus Rule and state law provide penalties for covered entities, business associates, and their subcontractors and records owners, respectively that misuse or improperly disclose PHI.

Starting April 14, 2013, HIPAA requires us to provide you with the Notice of our legal duties and the privacy practices we are required to follow when you first come into our office for healthcare services. If you have any questions about this Notice, please ask to speak to our HIPAA Privacy Officer.

Our Providers, clinical staff, employees, Business Associates (outside contractors we hire), their subcontractors and other involved parties follow the policies and procedures set forth in this Notice. If at this facility, your primary caretaker/provider is unable to assist you (i.e., illness, on-call coverage, vacation, etc.), we may provide you with the name of another healthcare provider outside our practice for you to consult with. IF we do so, that provider will follow the policies and procedures set forth in this Notice or those established for his or her practice, so long as they substantially conform to those for our practice.

## OUR RULES ON HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Under the law, we must have your signature on a written, dated Consent Form and/or Authorization Form of Acknowledgement of this Notice, before we will use or disclose your PHI for certain purposes as detailed in the rules below.

**Documentation**-You will be asked to sign an Authorization/Acknowledgement form when you receive this Notice of Privacy Practices. If you did not sign such a form or need a copy of the one you signed, please contact our office. You may revoke your consent or authorization at any time (unless we already have acted based on it) by submitting our Revocation Form in writing to us at our address listed above. Your revocation will take effect when we actually receive it. We cannot give it retroactive status, so it will not affect any use of disclosure that occurred in our reliance upon your consent of Authorization prior to revocation (i.e. if after we provide services to you, you revoke your authorization/acknowledgement in order to prevent us from billing or collecting for those services. Your revocation will have no effect because we relied on your authorization/acknowledgement to provide services before you revoked it).

**General Rule**-if you do not sign our Authorization/Acknowledgement Form or if you revoke it, as a general rule (subject to exceptions described below under "Healthcare Treatment, Payment, and Operations Rule" and "Special

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Rules"), we cannot in any manner use or disclose to anyone (excluding you but including payers and Business Associates) your PHI or any other information in your medical record. By law, we are unable to submit claims to payers under assignment of benefits without your signature on our Authorization/Acknowledgement Form. You will, however, be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under the new Omnibus Rule. We will not condition treatment on your signing and authorization/acknowledgement, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the authorization/acknowledgement or revoke it.

**Healthcare Treatment, Payment and Operations Rule**

With your signed consent, we may use or disclose your PHI in order:

- To provide you with or coordinate healthcare treatment and services. For example, we may review your health history form to develop a diagnosis and treatment plan, consult with other doctors about your care, delegate tasks to ancillary staff, call in prescriptions to your pharmacy, disclose needed information to your family or others so they may assist you with home care, arrange appointments with other healthcare providers, schedule lab work for you, etc.
- To bill or collect payment from you, an insurance company, a managed care organization, a health benefits plan or another third party. For example, we may need to verify your insurance coverage, submit your PHI on claim forms in order to get reimbursed for our services, obtain pre-treatment estimates or prior authorizations from your health plan or provide your x-rays because your health plan requires them for payment. Remember, you will be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under this new Omnibus Rule.
- To run our office, assess the quality of care our patients receive and provide you with customer service. For example, to improve efficiency and reduce costs associated with missed appointments, we may contact you by phone, mail or otherwise remind you of scheduled appointments, we may leave messages with whomever answers your phone or email to contact us (but we will not give out detailed PHI), we may tell you about or recommend health related products and complementary or alternative treatments that may interest you, we may review your PHI to evaluate our staff's performance, or our Privacy Officer may review your records to assist you with complaints. If you prefer that we not contact you with appointment reminders or information about treatment alternatives or health related products and services please notify us in writing at our address listed above and we will not use or disclose your PHI for these purposes.
- New HIPAA Ominbus Rule does not require that we provide the above notice regarding Appointment Reminders, Treatment information nor Health Benefits, but we are including theses as a courtesy so you understand our business practices with regards to your PHI.

Additionally, you should be made aware of these protection laws on your behalf, under the new HIPAA Ombibus Rule:

- That Health Insurance plans that underwrite cannot use or disclose genetic information for underwriting purposes (this excludes certain long-term care plans). Health plans that post their NOPPS on their websites must post these Omnibus Rule changes on their sites by the effective date of the Omnibus Rule, as well as notify you by US Mail by the Omnibus Rules effective date. Plans that do not post their NOPPS on their website must provide you information about Omnibus Rule changes within 60 days of these federal revisions.
- Psychotherapy Notes maintained by a healthcare provider must state in their NOPPS that they can allow "use and disclosure" of such notes only with your written authorization.

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**Special Rules**

Notwithstanding anything else contained in this Notice, only in accordance with applicable HIPAA Omnibus Rule, and under strictly limited circumstances, we may use or disclose your PHI without your permission, consent or authorization for the following purposes:

- When required under federal, state, or local law
- When necessary, in emergencies to prevent a serious threat to your health and safety of other persons
- When necessary for public health reasons (i.e. prevention or control of disease, injury or disability, reporting abuse, neglect or exploitation of children, disabled adults or the elderly, or domestic violence)
- For federal or state government health care oversight activities (i.e. civil rights laws, fraud and abuse investigations, audits, investigations inspections, licensure or permitting, government programs, etc.)
- For judicial and administrative proceedings and law enforcement purposes (i.e. in response to a warrant, subpoena or court order, by providing PHI to coroners, medical examiners and funeral directors to locate missing persons, identify deceased persons or determine cause of death)
- For Worker's Compensation purposes (i.e. we may disclose your PHI if you have claimed health benefits for a work related injury or illness)
- For intelligence, counterintelligence or other national security purposes (i.e. Veteran's Affairs, U.S. military command, other government authorities or foreign military authorities may require us to release PHI about you)
- For organ and tissue donation (i.e. if you are an organ donor, we may release your PHI to organizations that handle organ, eye or tissue procurement, donation and transplantation)
- For research projects approved by an institutional review board or a privacy board to ensure confidentiality (i.e. if the researcher will have access to your PHI because involved in your clinical care, we will ask you to sign an authorization)
- To create a collection of information that is "de-identified" (i.e. it does not personally identify you by name, distinguishing marks or otherwise and no longer can be connected to you)
- To family members, friends and others but only if you are present and verbally give permission. We give you an opportunity to object and if you do not, we reasonably assume, based on our professional judgement and the surrounding circumstances, that you do not object (i.e. you allow someone to be present in the operating or exam room or area during treatment or into the conference area when we are discussing your PHI); we reasonably infer that it is in your best interest (i.e. to allow someone to pick up your records because they knew you were our patient and you asked them in writing with your signature to do so); or it is an emergency situation involving you or another person (i.e. your minor child or ward) and, respectively, you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because after a reasonable attempt, we have been unable to locate you. In these emergency situations we may, based on our professional judgment and the surrounding circumstances, determine that disclosure is in the best interests of you or the other person, in which case we will disclose PHI but only as it pertains to the care being provided and we will notify you of the disclosure as soon as possible after the care is completed. **As per HIPAA law 164.512(j)(I)...(A) is necessary to prevent or lessen a serious or imminent threat to the health and safety of a person or the public and (B) is to person or persons reasonably able to prevent or lessen that threat.**

**Minimum Necessary Rule**

Our staff will not use or access your PHI unless it is necessary to do their jobs (i.e. doctors uninvolved in your care will not access your PHI; ancillary clinical staff caring for you will not access your billing information; billing staff will not access your PHI except as needed to complete the claim form for the latest visit; janitorial staff will not access your PHI). All of our team members are trained in HIPAA Privacy rules and sign strict Confidentiality Contracts with

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regards to protecting and keeping private your PHI. So do our Business Associates and their Subcontractors. Know that your PHI is protected several layers deep with regards to our business relations. Also, we disclose to others outside our staff, only as much of your PHI as is necessary to accomplish the recipients' lawful purposes. Still in certain cases, we may use and disclose the entire contents of your medical record:

- To you (and your legal representatives as stated above) and anyone else you list on a Consent or Authorization to receive a copy of your records.
- To healthcare providers for treatment purposes (i.e. making diagnosis and treatment decisions or agreeing with prior recommendations in the medical record)
- To the U.S. Department of Health and Human Services (i.e. in connection with a HIPAA complaint)
- To others as required under federal or state law
- To our Privacy Officer and others as necessary to resolve your complaint or accomplish your request under HIPAA (i.e. clerks who copy records need access to your entire medical record)

In accordance with HIPAA law, we presume that requests for disclosure of PHI from another Covered Entity (as defined in HIPAA) are for the minimum necessary amount of PHI to accomplish the requestor's purpose. Our Privacy Officer will individually review unusual or non-recurring requests for PHI to determine the minimum necessary determination based on, but not limited to, the following factors:

- The amount of information being disclosed
- The number of individuals or entities to whom the information is being disclosed
- The importance of the use or disclosure
- The likelihood of further disclosure
- Whether the same result could be achieved with de-identified information
- The technology available to protect confidentiality of the information
- The cost to implement administrative, technical and security procedures to protect confidentiality

If we believe a request from others for disclosure of your entire medical record is unnecessary, we will ask the requestor to document why this is needed. We will retain that documentation and make it available to you upon request.

**Incidental Disclosure Rule**

We will take reasonable administrative, technical and security safeguards to ensure the privacy of your PHI when we use or disclose it (i.e. we shred all paper contain PHI, require employees to speak with privacy precautions when discussing PHI with you, we use computer passwords and change them periodically (I.e. when an employee leaves us), we use firewall and router protection to the federal standard, we back up our PHI data off site and encrypted to federal standard, we do not allow unauthorized access to areas where PHI is stored or filed and/or we have any unsupervised Business Associates sign Business Associate Confidentiality Agreements).

However, in the event that there is a breach in protecting your PHI, we will follow federal guidelines to HIPAA Omnibus Rule Standard to first evaluate the breach situation using the Omnibus Rule, 4-Factor Formula for Breach Assessment. Then we will document the situation, retain copies of the situation on file, and report all breeches (other than low probability as prescribed by the Omnibus Rule) to the U.S. Department of Health and Human Services at: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationbrinstruction.html

We will also make proper notification to you and any other parties of significance as required by HIPAA Law.

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**Business Associate Rule**

Business Associates are defined as: an entity, (non-employee) that in the course of their work will directly/indirectly use, transmit, view, transport, hear, interpret, process or other PHI for this Facility.

Business Associates and other third parties (if any) that receive your PHI from us will be prohibited from re-disclosing it unless required to do so by law or you give prior express written consent to the re-disclosures. Nothing in our Business Associate agreement will allow our Business Associate to violate this re-disclosure prohibition. Under Omnibus Rule, Business Associates will sign a strict confidentiality agreement binding them to keep your PHI protected and report any compromise of such information to us, you and the U.S. Department of Health and Human Services, as well as other required entities. Our Business Associates will also follow Omnibus Rule and have any of their Subcontractors that may directly or indirectly have contact with your PHI, sign Confidentiality Agreements to Federal Omnibus Standard.

**Super-confidential information Rule**

If we have PHI about you regarding communicable diseases, disease testing, alcohol or substance abuse diagnosis and treatment, or psychotherapy and mental health records (super-confidential information under the law), we will not disclose it under the General or Healthcare Treatment, Payment and Operations Rules (see above) without you first signing and properly completing our Consent form (i.e. you specifically must initial the type of super confidential information we are allowed to disclose). If you do not specifically authorize disclosure by initialing the super-confidential information, we will not disclose it unless authorized under the Special rules (see above) (i.e. we are required by law to disclose it). If we disclose super-confidential information (either because you have initialed the consent form or the Special Rules authorizing us to do wo), we will comply with state and federal law that requires us to warn the recipient in writing that re-disclosure is prohibited.

**Changes to Privacy Policies Rule**

We reserve the right to change our privacy practices (by changing the terms of this Notice) at any time as authorized by law. The changes will be effective immediately upon us making them. They will apply to all PHI we create or receive in the future, as well as to all PHI created or received by us in the past (i.e. to PHI about you that we had before the changes took effect). If we make changes, we will post the changed Notice, along with its effective date, in our office and on our website. Also, upon request, you will be given a copy of the current Notice.

**Authorization Rule**

We will not use or disclose your PHI for any purpose or to any person other than as stated in the rules above without your signature on our specifically worded, written Authorization/Acknowledgement Form (not a Consent or an Acknowledgement). If we need your Authorization, we must obtain it via a specific Authorization Form, which may be separate from any Authorization/Acknowledgement we may have obtained from you. We will not condition your treatment here on whether you sign the Authorization (or not).

**Marketing and Fundraising Rules**

**Limitations on the disclosure of PHI regarding Remuneration**

The disclosure or sale of your PHI without authorization is prohibited. Under the new HIPAA Omnibus Rule, this would exclude disclosures for public health purposes, for treatment/payment for healthcare, for the sale, transfer, merger, or consolidation of all or part of this facility and for related due diligence, to any of our Business

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Associates, in connection with the business associate's performance of activities for this facility, to a patient or beneficiary upon request, and as required by law. In addition, the disclosure of your PHI for research purposes or for any other purpose permitted by HIPAA will not be considered a prohibited disclosure if the only reimbursement received is "a reasonable, cost-based fee" to cover the cost to prepare and transmit your PHI which would be expressly permitted by law. Notably, under the Omnibus Rule, an authorization to disclose PHI must state that the disclosure will result in remuneration to the Covered Entity. Notwithstanding the changes in the Omnibus Rule, the disclosure of limited data sets (a form of PHI with a number of identifiers removed in accordance with specific HIPAA requirements) for remuneration pursuant to existing agreements is permissible until September 22, 2014, so long as the agreement is not modified within one year before that date.

**Limitations on the Use of the PHI for Paid Marketing**

We will, in accordance with Federal and State Laws, obtain your written authorization to use or disclose your PHI for marketing purposes, (i.e. to use your photo in ads) but not for activities that constitute treatment or healthcare operations. To clarify, **Marketing** is defined by HIPAA's Omnibus Rule, as "a communication about a product or service that encourages recipients...to purchase or use the product or service." Under the Omnibus Rule, we will obtain a written authorization from you prior to recommending you to an alternative therapist, or non-associated Healthcare Covered Entity.

Under Omnibus Rule, we will obtain your written authorization prior to using your PHI or making any treatment or healthcare recommendations, should financial remuneration for making the communication be involved from a third party whose product or service we might promote (i.e. businesses offering this facility incentives to promote their products or services to you). This will also apply to our Business Associate who may receive such remuneration for making a treatment or healthcare recommendations to you. All such recommendations will be limited without your expressed written permission.

We must clarify to you that financial remuneration does not include "as in-kind payments" and payments for a purpose to implement a disease management program. Any promotional gifts of nominal value are not subject to the authorization requirement, and we will abide by the set terms of the law to accept or reject these.

The only exclusion to this would include: "refill reminders", so long as the remuneration for making such a communication is "reasonably related to our cost" for making such a communication. In accordance with the law, this facility and our Business Associates will only seek reimbursement from you for permissible costs that include labor, supplies, and postage. Please note that "generic equivalents", "adherence to take medication as directed" and "self-administered drug or delivery system communications" are all considered to be "refill reminders."

Face-to-face marketing communications, such as sharing with you, a written product brochure or pamphlet, is permissible under current HIPAA Law.

**Flexibility on the Use of PHI for Fundraising**

Under HIPAA Omnibus Rule, use of PHI is more flexible and does not require your authorization should we choose to include you in any fundraising efforts attempted at this facility. However, we will offer the opportunity for you to "opt out" of receiving future fundraising communications. Simply let us know that you want to "opt out" of such situations. There will be a statement on your **HIPAA Patient acknowledgement Form** where you can choose to "opt out". Our commitment to care and treat you will in no way affect your decision to participate or not in our fundraising efforts.

Peaceful Balance
Health & Wellness Services, LLC
Lorraine W. Bock, DNP, CRNP

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**Improvements to Requirements for Authorizations Related to Research**

Under HIPAA Omnibus Rule, we may seek authorizations from you for the use of your PHI for future research. However, we would have to make clear what those uses are in detail.

Also, if we request of you a compound authorization with regards to research, this facility will clarify that when a compound authorization is used, and research related treatment is conditioned upon your authorization, the compound authorization will differentiate between the conditioned and unconditioned components.

**YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION**

If you got this Notice via email or website, you have the right to get, at any time, a paper copy by asking our Privacy Officer. Also, you have the following additional rights regarding PHI we maintain about you:

**To Inspect and Copy**

You have the right to see and get a copy of your PHI including, but not limited to, medical and billing records by submitting a written request to our Privacy Officer. Original records will not leave the premises, will be available for inspection only during our regular business hours, and only if our Privacy Officer is present at all times. You may ask us to give you the copies in a format other than photocopies (and we will do so unless we determine that it is impractical) or ask us to prepare a summary in lieu of the copies. We may charge you a fee not to exceed state law to recover our costs (including postage, supplies, and staff time as applicable, but excluding staff time for search and retrieval) to duplicate or summarize your PHI. We will not condition release of the copies on summary of payment or your outstanding balance for professional services if you have one). We will comply with Federal Law to provide your PHI in an electronic format within thirty days, to Federal specifications, when you provide us with proper written request. Paper copy will also be made available. We will respond to requests in a timely manner without delay for legal review, or, in less than thirty days if submitted in writing and in ten business days or less if malpractice litigation or pre-suit production is involved. We may deny your request in certain limited circumstances (i.e. we do not have the PHI; it came from a confidential source, etc.). If we deny your request, you may ask for a review of that decision. If required by law, we will select a licensed healthcare professional (other than the person who denied your request initially) to review the denial and we will follow his or her decision. If we select a licensed healthcare professional who is not affiliated with us, we will ensure a Business Associate Agreement is executed that prevents re-disclosure of your PHI without your consent by that outside professional.

**To Request Amendment/Correction**

If another provider involved in your care tells us in writing to change your PHI, we will do so as expeditiously as possible upon receipt of the changes and will send you written confirmation that we have made the changes. If you think PHI we have about you is incorrect, or that something important is missing from your records, you may ask us to amend or correct it (as long as we have it) by submitting a "**Request for Amendment/Correction**" form to our Privacy Officer. We will act on your request withing thirty days from receipt, but we may extend our response time (within the thirty day period) no more than once and by nor more than thirty days, or as per Federal Law allowances, in which case we will notify you in writing why and when we will be able to respond. If we grant your request, we will let you know within five business days, make the changes within five business days) tell you why and how to file a complaint with us if you disagree, that you may submit a written disagreement with our denial (and we may submit a written rebuttal and give you a copy of it), that you may ask us to disclose your initial request and our denial when we make future disclosure of PHI pertaining to your request, and that you may complain to us and the U.S. Department of Health and Human Services.

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**To an Accounting of Disclosures**

You may ask us for a list of those who got your PHI from us by submitting a "**Request for Accounting of Disclosures**" form to us. The list will not cover some disclosures (i.e. PHI given to you, given to your legal representative, given to others for treatment, payment or healthcare operations purposes). Your request must state in what form you want the list (i.e. paper or electronically) and the time period you want us to cover, which may be up to but not more than the last six years (excluding dates before October 31, 2018). If you ask us for this list more than once in a twelve-month period, we may charge you a reasonable, cost based fee to respond, in which case we will tell you the cost before we incur it and let you choose if you wish to withdraw or modify your request.

**To Request Restrictions**

You may ask us to limit how your PHI is used and disclosed (i.e. in addition to our rules as set forth in this Notice) by submitting a written "**Request for Restrictions on Use Disclosure**" form to us (i.e. you may not want us to disclose your surgery to family members or friends involved in paying for our services or providing your home care). If we agree to these additional limitations, we will follow them except in an emergency where we will not have time to check for limitations. Also, in some circumstances we may be unable to grant your request (i.e. we are required by law to use or disclose your PHI in a manner that you want restricted you signed an Authorization Form, which you may revoke that allows us to use or disclose your PHI in the manner you want restricted; in an emergency).

**To Request Alternative Communications**

You may ask us to communicate with you in a different way or at a different place by submitting a written "**Request for Alternative Communication**" form to us. We will not ask you why and we will accommodate all reasonable requests (which may include: to send appointment reminders in closed envelopes rather than by postcards to send your PHI to a post office box instead of your home address, to communicate with you at a telephone number other than your home number). You must tell us the alternative means or location you want us to use and explain to our satisfaction how payment to us will be made if we communicate with you as you request.

**To Complain or Get More Information**

We will follow our rules as set forth in this Notice. If you want more information or if you believe your privacy rights have been violated (i.e. you disagree with a decision of ours about inspection/copying, amendment/correction, accounting of disclosures, restrictions or alternative communications), we want to make it right. We will never penalize you for filing a complaint. To do so, please file a formal, written complaint within 180 days with:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, DC 20201
877-696-6775

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Or, submit a written Complaint form to us at the following address:

Peaceful Balance Health & Wellness, LLC
Attn: Privacy Officer
9 East High St.-Rear
Carlisle, PA 17015
717-440-0498

You may get your "**HIPAA Complaint**" form by calling our office.

These privacy practices are in accordance with the original HIPAA enforcement effective April 14, 2003, and undated to Omnibus Rule effective March 26, 2013, and will remain in effect until we replace them as specified by Federal and/or State Law.

**Faxing and Emailing Rule**

When you request us to fax or email your PHI as an alternative communication, we may agree to do so, but only after having our Privacy Officer or treating provider review that request. For this communication, our Privacy Officer will confirm that the fax number or email address is correct before sending the message and ensure that the intended recipient has sole access to the fax machine or computer before sending the message; confirm receipt, locate our fax machine or computer in a secure location so unauthorized access and viewing is prevented; use a fax cover sheet so the PHI is not the first page to print out (because unauthorized persons may view the top page), and attach an appropriate notice to the message. Our emails are all encrypted per Federal Standard for your protection.

**Practice Transition Rule**

If we sell our practice, or patient records (including but not limited to your PHI) may be disclosed and physical custody may be transferred to the purchasing healthcare provider, but only in accordance with the law. The healthcare provider who is the new records owner will be solely responsible for ensuring privacy of your PHI after the transfer and you agree we will have no responsibility for (or duty associated with) transferred records. If all the owners of our practice die, our patient records (including but not limited to your PHI) must be transferred to another healthcare provider within 90 days to comply with State & Federal Laws. Before we transfer records in either of these two situations, our Privacy Officer will obtain a Business Associate Agreement from the purchase and review your PHI for super-confidential information (i.e. communicable disease records), which will not be transferred without your express written authorization (indicated by your initials on our Consent form).

**Inactive Patient Records**

We will retain your records for seven years from your last treatment or examination, at which point you will become an inactive patient in our practice, and we may destroy your records at that time (but records of inactive minor patients will not be destroyed before the child's eighteenth birthday). We will do so only in accordance with the law (i.e. in a confidential manner, with a Business Associate Agreement prohibiting re-disclosure if necessary).

**Collections**

If we use or disclose your PHI for collections purposes, we will do so only in accordance with the law.

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# HIPAA OMNIBUS RULE

## PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.

Patient Name:_____ DOB_____

_____ _____
Patient/Representative Signature Date

If the patient listed above is a minor or unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____
Print Name Relationship to Patient

*** I agree to have Peaceful Balance Health & Wellness, LLC use the external pharmacy verification application as applicable for an accurate medication reconciliation history using pharmacy retrieval data.

_____ _____
Patient/Representative Signature Date

If the patient listed above is a minor or unable to sign and you are a parent legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____
Print Name Relationship to Patient

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# Authorization for Test Results

Patient Name:_____ DOB:_____

Peaceful Balance Health & Wellness will attempt to use your patient health portal as the first means of communication when appropriate. If it becomes necessary to communicate by other means, please provide your preferred method of contact by checking the Abnormal/Normal boxes below. In doing so, you are giving permission to leave a voicemail or secure email for your (or your Child's) test results.

| Abnormal | Normal | Preferred Method | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Primary Phone Number on File |
| ☐ | ☐ | ☐ | Secondary (cell) Phone Number on File |
| ☐ | ☐ | ☐ | Email: |

Name of Nearest Relative:

Name: _____ Phone: _____ Relationship: _____

I give permission for you to share my medical information with this person ☐YES ☐NO

Name: _____ Phone: _____ Relationship: _____

I give permission for you to share my medical information with this person ☐YES ☐NO

I understand it is my responsibility to have the ordered tests completed and have been explained the importance and reasoning for testing, I understand Peaceful Balance Health & Wellness contacts all patients with normal and abnormal test results and it is my responsibility to contact Peaceful Balance Health & Wellness if I have not received the results. This agreement Will remain in effect indefinitely.

By signing these agreements, I acknowledge it is my responsibility to inform Peaceful Balance Health & Wellness of any changes of information.

_____ _____

Patient/Representative Signature Date

If the patient listed above is a minor or unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____

Print Name Relationship to Patient

Peaceful Balance Health & Wellness, L.L.C.
Lorraine W. Bock, DNP, CRNP
9 East High Street – Rear
Carlisle PA 17015
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# CONSENT TO COMMUNICATE VIA TEXT AND EMAIL

I _____ agree that Peaceful Balance Health and Wellness Services, LLC (PBHW) and its employees and providers have my consent to communicate with me via text messaging and e-mail, including protected health information (PHI) such as my name, date of birth, and medical conditions. I fully understand and acknowledge that communication through these methods is not HIPAA compliant and that any protected health information shared via text and/or email could be compromised. I agree to hold harmless, Peaceful Balance Health and Wellness Services, LLC and its employees and providers should information communicated vit text message or email result in a breach or release of my PHI. I further acknowledge that I understand that the CareSpan patient portal is a HIPAA compliant means through which PBHW and its employees and providers can contact me with information about my health.

Date_____

Patient Name_____

Signature_____

PBHW Employee Obtaining Consent_____