SCENT
ALLERGY & SLEEP MEDICINE

NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Patient Date of Birth: _____

This notice serves as a single notice for several health care providers that share common ownership or control: South Carolina ENT, Allergy & Sleep Medicine, P.A., Carolina Hearing Institute, LLC, SC FYZICAL, LLC, and Somnus USA II, LLC (collectively referred to herein as "SCENT").

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.

As your healthcare provider, we will maintain a record of your visits that contain your symptoms, reports of examination and test results, diagnoses, treatments, correspondence with other providers, and plans for future care or treatment.

Your health record is the physical property of SCENT; however, the information it contains belongs to you. You have the following rights, and we request that you notify our administrative offices, by calling (803) 408-3277 of your requests for any of these actions:

A. Request Restrictions: You have a right to request restrictions on the use of your information for treatment, payment or healthcare operations or to family members and others involved in your care; however, we are not required to agree to the restriction except in the case of a disclosure to your health insurer if you have has paid in full.
B. Obtain a paper copy of this notice: You have a right to receive a paper copy of this Notice.
C. Inspect and copy: You have a right to inspect and receive a copy of your health information. If you request a copy of your information, **you may be charged a reasonable fee for photocopying, retrieval, labor, postage, and supplies used.**
D. Amend: You have the right to request that we amend your health information.
E. Obtain an Account of Disclosures: You have the right to request a list of certain disclosures of information that have been made about you. This list includes disclosures of your information for treatment, payment, or healthcare purposes and is within a specified period of up to six (6) years. The first list of disclosures is provided as a complimentary service to you, but you may be charged a reasonable fee for additional requests made within a twelve-month (12) period.
F. Request communication of your health information: You have the right to request that you receive communications regarding your information in a certain manner or at a certain location.
G. Revoke your authorization for Disclosure: You have the right to revoke an authorization for disclosure of information that was previously given.

Our practice is required to:

A. Be confidential: We will maintain the privacy of your health information for 50 years after your death.
B. Provide a copy of this notice: We will provide you with a copy of this notice of our legal duties and privacy practices with respect to the information we collect and maintain about you.
C. Abide by the terms of this notice.
D. Notify you of restriction limitations: We will notify you if we are unable to agree to a requested restriction of your information.
E. Provider alternative means or alternative provisions effective for all protected health information we keep. Should our information practices change, we will notify you of these changes when you return to our office. We will not use or disclose your health information without your authorization, except as described in this notice.

<u>More Information</u>

A. If you have a question or would like additional information, you may contact our administrative offices by calling (803) 408-3277.
B. If you have a concern about the privacy of your information, you may contact our administrative offices by calling (803) 408-3277. Your concerns will be responded to by our practice. You may file a complaint with the 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. Under no circumstance will you be retaliated against for filling a complaint.

<u>Examples of Disclosures of Information</u>

A. Treatment: We will use your health information for treatment purposes. An example – information given to a nurse or physician will be recorded in your health record and used to determine the best treatment for you. Members of the healthcare teams will document your treatment goals, actions taken, and clinical observations. We will provide your healthcare providers with copies of various reports that will help them to treat you for any subsequent conditions that may arise.
B. Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, your diagnoses, treatments, and supplies used.

C. Healthcare Operations: The physicians and members for your healthcare team may use the information to evaluate the quality of care you received as well as the care received by others like you. This information will be used to improve the effectiveness of healthcare operations and services we provide.
D. Business Associates: There are some services provided through contracts with business associates. As an example, we will contract with a copy that provides information services for the computer system we operate. When these services are contracted, we may disclose your health information to this business associate, so that they can perform the work we require. To provide your health information, the business associate must appropriately safeguard your information.
E. Notification: We may disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your general condition.
F. Communication with Family: We will use good judgement in disclosing to a family member, or any other person you identify, health information relevant to that person's involvement in your care.
G. Interpretation Services: We provide interpretation services, to include American Sign Language and foreign languages, through a contracted interpretation service. Interpretation services may also be supplied by some insurers. Should you require the use of our contracted interpretation service or interpretation services provided by your insurer, we may disclose your information to individuals associated with these service providers for communication between the healthcare provider and the patient / patient representative regarding the patient's health. Like the Practice, the American Sign Language and foreign language interpreters have a duty to keep your protected health information confidential.
H. Research: We will disclose only limited information to approved researchers.
I. Funeral Director, Medical Examiners and Coroners: We may disclose health information to funeral directors, medical examiners and coroners consistent with state law that allows them to carry out their duties.
J. Organ Donation: If you are an organ donor, we may disclose your information to organizations that help procure, bank, or transport organs for tissue donation and transplantation purposes.
K. Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.
L. Food and Drug Administration: We may disclose to the FDA, health information relative to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.
M. Worker's Compensation: In accordance with state law, we may disclose health information as is required for processing a claim under worker's compensation.
N. Public Health: Under South Carolina law, we may disclose your health information to the health department to prevent or control disease, injury, or disability.
O. To avert a serious threat to health or safety. We may, consistent with applicable law and standards of ethical conduct, use or disclose medical information if we believe that the use or disclosure is necessary to prevent or lessen a serious threat to the health or safety of a person or the public; provided that, if a disclosure is made, it must be to a person(s) reasonably able to prevent or lessen the threat.
P. Correctional Institution: If you are an inmate or reside in a correctional institution, we may disclose to the institution or its agents, health information that is needed for your health or the health and safety of other individuals.
Q. Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
R. For military activities. We may use or disclose medical information of individuals who are Armed Forces personnel for activities deemed necessary to assure proper execution of military missions, provided certain conditions are met.
S. For national security and intelligence activities. We may disclose medical information to authorized federal officials for the conduct of lawful intelligence, counterintelligence, and other national security activities authorized by the National Security Act and implementing authority.
T. Health Investigation: Federal and state laws made provisions for your health information to be released to appropriate health authorities provided a member of our staff or business associate believes in good faith, that we have engaged in unlawful conduct or have otherwise endangered one or more patients, workers, or the public.
U. Other Disclosure: All other uses and disclosures of your information will only be made with your written authorization. If you have authorized us to use or disclose information about you, you may revoke this authorization at any time.

Patient Name: _____ Patient Date of Birth: _____

Agreement to Receive Electronic Communication

By signing below, I agree that SCENT may send the following types of emails and text messages (including automated messages) to the mobile telephone number and/or email address, as applicable, that I have provided to SCENT: appointment confirmations and reminders; other practice communications such as clinical care reminders and information, pre- or post-visit instructions, messages regarding my health and health plan and/or diagnoses or treatment, billing-related messages, eligibility information or questions, and occasional practice updates such as office moves or weather closings; updates on available treatment offerings and services, services and programs that may be of interest to me, refill reminders, promotions, and innovations in ENT products and care.

Initial to indicate consent: _____ Email _____ Text Messaging

I understand that I have the right to opt-out of receiving certain such communications by following the instructions provided in an applicable message. However, I understand that if I choose to opt out, I may experience an impact in my experience with the service(s) that rely on communications via text messaging and/or email communications. I also understand that I may continue to receive certain time-sensitive messages that do not require consent (such as emergency notifications) even after opting out or unsubscribing.

I agree that SCENT may send me messages by text or email (as selected above) that are unsecure. Text messages and email communications have inherent privacy risks, including that unencrypted text messages and email communications are not secure and could be accessed by an unauthorized party, intercepted, or altered without my knowledge or authorization.

_____ _____ _____

Signature of patient/authorized representative Print name if other than patient Date

By opting-in to email communication from (insert clinic name), you agree to receive the types of emails described above. You can revoke your consent to receive emails at any time by using the unsubscribe link found at the bottom of every email.

By opting-in to SMS messages from SCENT, you agree to receive automated promotional messages. This agreement isn't a condition of any purchase. We will send no more than four (4) messages/month. Msg & Data rates may apply. Reply STOP to end anytime after receiving your initial confirmation message. Terms of Service and Privacy Policy can be found on our website.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I hereby acknowledge that I have been given an opportunity to review the privacy practices at SCENT. I understand that I may obtain a copy of the Notice of Privacy Practices. This Notice has been issued and considered effective on the date signed. We will keep this signed form on file for a minimum of six (6) years.

Signature of Patient/Representative Relationship to Patient Date

Signature of Practice Representative Date