Elite DNA Therapy Services
a comprehensive approach

Adult Intake Form

Demographics

Patient Name: _____ [ ] Male [ ] Female
Date of Birth: _____ Patient Social Security Number: _____
Ethnicity: _____ Preferred Language: _____
Current Diagnosis (if any): _____
Name (Person completing this form): _____ Relationship to Patient: _____
Home Address: _____ Primary Phone: _____
_____ Secondary Phone: _____

Doctor Information

Primary Physician: _____ Referring Physician: _____
Phone: _____ Phone: _____Specialty: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information

Primary Insurance Type: _____ Secondary Insurance Type: _____
Member ID Number: _____ Member ID Number: _____
Group Number: _____ Group Number: _____
Policy Holder's Name: _____ Policy Holder's Name: _____
Policy Holder's DOB: _____ Policy Holder's DOB: _____
Policy Holder's Social Security Number: _____ Policy Holder's Social Security Number: _____

Guardian Information (Complete If Applicable)

Guardian Name: _____ Occupation: _____
Relationship to Patient: _____ Home Phone: _____
Date of Birth: _____ Cell Phone: _____
Social Security Number: _____ Work Phone: _____
Marital Status: _____ E-mail Address: _____

Guardian Name: _____ Occupation: _____
Relationship to Patient: _____ Home Phone: _____
Date of Birth: _____ Cell Phone: _____
Social Security Number: _____ Work Phone: _____
Marital Status: _____ E-mail Address: _____

Presenting Concerns

Please describe your primary concerns. (How long have you noticed this?) _____

_____

Have you already tried to address these concerns? [ ] Yes [ ] No [ ] Unsure

Were the efforts effective? [ ] Yes [ ] No [ ] Unsure

Was there an event that caused you to seek treatment now? [ ] Yes [ ] No [ ] Unsure

Current Symptoms Checklist

[ ] Depressed mood
[ ] Unable to enjoy activities
[ ] Sleep pattern disturbance
[ ] Loss of interest
[ ] Decreased concentration/forgetfulness
[ ] Racing thoughts
[ ] Impulsivity
[ ] Excessive energy
[ ] Increased irritability
[ ] Crying spells
[ ] Excessive worry
[ ] Anxiety attacks
[ ] Avoidance
[ ] Repetitive behaviors
[ ] Thoughts of harming someone else
[ ] Increased risky behavior
[ ] Increased libido
[ ] Decreased need for sleep
[ ] Other: _____

Have you ever had feelings or thoughts that you didn't want to live? [ ] Yes [ ] No [ ] Unsure

Do you currently feel that you don't want to live? [ ] Yes [ ] No [ ] Unsure

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? [ ] Yes [ ] No [ ] Unsure

Would anything make it better? [ ] Yes [ ] No [ ] Unsure

Have you ever thought about how you would kill yourself? [ ] Yes [ ] No [ ] Unsure

Is the method you would use readily available? [ ] Yes [ ] No [ ] Unsure

Have you planned a time for this? [ ] Yes [ ] No [ ] Unsure

Is there anything that would stop you from killing yourself? [ ] Yes [ ] No [ ] Unsure

Have you ever tried to kill or harm yourself before? [ ] Yes [ ] No [ ] Unsure

Medical History

Date of last complete physical exam: _____

Any significant or relevant medical problems and age diagnosed:

[ ] Surgeries, age: _____
[ ] Illnesses, age: _____
[ ] Injuries, age: _____
[ ] Head Trauma, age: _____
[ ] Seizures, age: _____
[ ] Other: _____, age: _____

Have other specialties or other professionals have treated/are treating you: [ ] Yes [ ] No [ ] Unsure

Are you currently taking and medication? [ ] Yes [ ] No [ ] Unsure

Allergies: [ ] Yes [ ] No [ ] Unsure

Vision problems: [ ] Yes [ ] No [ ] Unsure

Hearing problems: [ ] Yes [ ] No [ ] Unsure

Medical History (continued)

Any other health problems: [ ] Yes [ ] No [ ] Unsure

Any disabilities that could impact you [ ] Yes [ ] No [ ] Unsure

For Women Only

Are you currently pregnant or do you think you might be pregnant? [ ] Yes [ ] No [ ] Unsure

Are you planning to get pregnant in the near future? [ ] Yes [ ] No [ ] Unsure

Birth control method: _____

Please mark all **past** psychiatric medications.

Antidepressants

[ ] Prozac (fluoxetine)
[ ] Zoloft (sertraline)
[ ] Luvox (fluvoxamine)
[ ] Celexa (citalopram)
[ ] Lexapro (escitalopram)
[ ] Paxil (paroxetine)
[ ] Pristiq (desvenlafaxine)
[ ] Cymbalta (duloxetine)
[ ] Effexor (venlafaxine)
[ ] Wellbutrin (Bupropion)
[ ] Remeron (mirtazapine)
[ ] Viibryd (vilazodone)
[ ] Trintellix (vortioxetine)
[ ] Elavil (amitriptyline)
[ ] Anafranil (clomipramine)
[ ] Sinequan (doxepin)
[ ] Tofranil (imipramine)
[ ] Pamelor (nortriptyline)
[ ] Savella (milnacipran)
[ ] Fetzima (levomilnacipran)
[ ] Other: _____

Anti-Anxiety (Anxiolytics)

[ ] Xanax (alprazolam)
[ ] Buspar (buspirone)
[ ] Ativan (lorazepam)
[ ] Vistaril (hydroxyzine)
[ ] Klonopin (clonaxepam)
[ ] Valium (diazepam)
[ ] Librium (chlordiazepoxide)
[ ] Tranxene (clorazepate)
[ ] Serax (oxazepam)
[ ] Other: _____

Typical Antipsychotics

[ ] Thorazine (chlorpromazine)
[ ] Haldol (haloperidol)
[ ] Other: _____

Atypical Antipsychotics/Mood Stabilizers

[ ] Abilify (aripiprazole)
[ ] Clozaril (clozapine)
[ ] Latuda (lurasidone)
[ ] Zyprexa (olanzapine)
[ ] Seroquel (quetiapine)
[ ] Risperdal (risperidone)
[ ] Geodon (ziprasidone)
[ ] Haldol (haloperidol)
[ ] Prolixin (fluphenazine)
[ ] Saphris (asenapine)
[ ] Rexulti (brexpiprazole)
[ ] Invega (paliperidone)
[ ] Fanapt (iloperidone)
[ ] Other: _____

Mood Stabilizers

[ ] Lithium
[ ] Tegretol (carbamazepine)
[ ] Neurontin (gabapentin)
[ ] Lamictal (lamotrigine)
[ ] Trileptal (oxcarbazepine)
[ ] Topamax (topiramate)
[ ] Depakote (valproate)
[ ] Other: _____

Sedatives/Sleep Aides

[ ] Ambien (zolpidem)
[ ] Sonata (zaleplon)
[ ] Rozerem (ramelteon)
[ ] Restoril (temazepam)
[ ] Desyrel (trazodone)
[ ] Lunesta (eszopiclone)
[ ] Belsomra (suvorexant)
[ ] Other: _____

ADHD Medications

[ ] Adderall (amphetamine)
[ ] Adderall XR
[ ] Evekeo (amphetamine)
[ ] Zenzedi (amphetamine)
[ ] Adzenys XR (amphetamine)
[ ] Concerta (methylphenidate)
[ ] Ritalin (methylphenidate)
[ ] Daytrana (methylphenidate)
[ ] Metadate (methylphenidate)
[ ] Dyanavel XR
[ ] Strattera (atomoxetine)
[ ] Quillivant XR
[ ] Kapvay (clonidine)
[ ] Tenex/Intuniv (gunanfacine)
[ ] Mydayis (mixed amphetamine salt)
[ ] Cotempla XR (methylphenidate)
[ ] Other: _____

Family History (Please indicate if any family members have been diagnosed or experience any of the following)

	Mother	Father	Sibling	Maternal Grandparents	Paternal Grandparents	Other
Depression						
Anxiety						
Substance abuse						
Learning disability						
ADHD						
Bipolar disorder						
Psychosis/Schizophrenia						
OCD						
Suicidal behavior						
Self-harm/cutting						
Seizure disorder						
Autism spectrum						
Intellectual disability						
Abuse						
Thyroid problem						
Other						

Psychiatric History

Have you ever received any of the following services or feelings?

- Individual Therapy: [ ] Yes [ ] No [ ] Unsure
- Family Therapy: [ ] Yes [ ] No [ ] Unsure
- Group Therapy: [ ] Yes [ ] No [ ] Unsure
- Psychological Testing: [ ] Yes [ ] No [ ] Unsure
- Inpatient (Hospital or Residential): [ ] Yes [ ] No [ ] Unsure
- Past Suicidal Ideation: [ ] Yes [ ] No [ ] Unsure
- Aggressive Behavior or Homicidal Ideation/Behavior: [ ] Yes [ ] No [ ] Unsure
- Previous Diagnosis: [ ] Yes [ ] No [ ] Unsure

Substance Abuse

Is substance abuse a primary treatment concern? [ ] Yes [ ] No [ ] Unsure

Have you ever been treated for alcohol or drug use or abuse? [ ] Yes [ ] No [ ] Unsure

Have many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Substance Abuse (continued)

Have you ever felt you ought to cut down on your drinking or drug use? [ ] Yes [ ] No [ ] Unsure
Have people annoyed you by criticizing your drinking or drug use? [ ] Yes [ ] No [ ] Unsure
Have you ever felt bad or guilty about your drinking or drug use? [ ] Yes [ ] No [ ] Unsure
Have you ever had a drink or used drugs first thing in the morning to steady your nerves? [ ] Yes [ ] No [ ] Unsure
Have you ever had a drink or used drugs first thing in the morning to get rid of a hangover? [ ] Yes [ ] No [ ] Unsure
Do you think you may have a problem with alcohol or drug use? [ ] Yes [ ] No [ ] Unsure
Have you used any street drugs in the past 3 months? [ ] Yes [ ] No [ ] Unsure
Have you ever abused prescription medication? [ ] Yes [ ] No [ ] Unsure

Tobacco History

Have you ever smoked cigarettes? [ ] Yes [ ] No [ ] Unsure
Do you currently smoke cigarettes? [ ] Yes [ ] No [ ] Unsure
How many packs per day on average? _____

Trauma History

Have you ever experienced or witnessed any kind of abuse? [ ] Yes [ ] No [ ] Unsure

- Emotional abuse: [ ] Yes [ ] No [ ] Unsure
- Physical abuse: [ ] Yes [ ] No [ ] Unsure
- Sexual abuse: [ ] Yes [ ] No [ ] Unsure
- Neglect: [ ] Yes [ ] No [ ] Unsure

Educational History

What is the highest-grade level / degree of education you have completed? _____

Work History

Are you currently: [ ] Working [ ] Student [ ] Unemployment [ ] Disabled [ ] Retired

- How long have you been in your present position? _____
- What is/was your occupation? _____
- Where do you work? _____
- What are your hours? _____

Relationship History and Current Family

Relationship Status:
[ ] Married for: _____ [ ] Single for: _____
[ ] Divorced for: _____ [ ] Widowed: _____
[ ] Partnered for: _____

How would you identify your sexual orientation? _____ [ ] Prefer Not to Answer
Are you sexually active? [ ] Yes [ ] No [ ] Unsure
Have you had any prior marriages? [ ] Yes [ ] No [ ] Unsure
Do you have children? [ ] Yes [ ] No [ ] Unsure
What are their ages and whom do they live with? _____
_____
Whom do you currently live with? _____

Legal History

Have you ever been arrested? [ ] Yes [ ] No [ ] Unsure
Have you ever been to jail? [ ] Yes [ ] No [ ] Unsure
Do you have any pending legal problems? [ ] Yes [ ] No [ ] Unsure

Spiritual Life

Do you belong to a religion or spiritual group? [ ] Yes [ ] No [ ] Unsure [ ] Prefer not to answer
Are there any cultural factors that could impact patient's treatment? [ ] Yes [ ] No [ ] Unsure

Any other information you wish the provider to know: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Printed Name of Parent or Guardian Relationship to Patient

_____ _____
Signature of Parent or Guardian Date

Elite DNA Therapy Services, LLC
General Consent for Treatment

Patient Name: _____ Date of Birth: _____

Consent for Treatment

I hereby voluntarily give my consent for myself, my child, or my family to receive one or more of the following services or treatments provided by Elite DNA Therapy Services, LLC: Psychiatry, Psychotherapy, Medication Management, Occupational Therapy (OT), Speech Therapy (ST), Advanced Behavioral Analysis (ABA), Transcranial Magnetic Stimulation (TMS), Mental Health, or Substance Abuse and Addiction Medicine services, all within the professional medical judgement and discretion of Elite DNA Therapy Services, LLC's doctors, nurse practitioners, and staff. I further consent to the collection and use of past and current medical and medicine history of patient, patient's family, patient's providers, including pharmacies from which prescriptions have been obtained. I consent to the use of photography for purposes of verifying identification of patients and/or identifying accompanying persons. Because I have the right to refuse services at any time, I understand and agree that my or my family's continued participation in services or treatments offered by Elite DNA Therapy Services, LLC implies informed consent. If I choose to revoke this consent, I understand that providers and/or clinic staff may not be able to provide to me, my child, or family members necessary services and treatments that have been recommended. I further understand that Elite DNA Therapy Services, LLC participates in educational programs and that students in these affiliated programs may be involved in care provided.

_____ (initials) I understand that potential benefits of undergoing services offered by Elite DNA Therapy Services, LLC may include improvement in functioning of myself or child and/or an increased understanding of myself and/or child. I understand that potential risks may include possible disagreement with opinions offered to me, and possible emotional distress concerning my situation. I understand that alternative procedures may include services provided by other psychologists, psychiatrists, or mental health professionals.

_____ (initials) I understand that while the evaluation and/or treatment will be based upon known principles and research, the practice is not an exact science. I acknowledge that no guarantees have been made to me concerning the results of evaluations and/or treatments or services provided by Elite DNA Therapy Services, LLC.

_____ (initials) I verify that I am the patient **OR** patient's legal guardian per Florida State Statute Chapter 744 for the above and furthermore certify that the information, records, and other documents I have provided to Elite DNA Therapy Services, LLC (either verbally or in writing) are accurate to the best of my knowledge.

_____ (initials) I hereby acknowledge that I have reviewed the Notice of Privacy Practice(NPP) and the Patients' Rights and Responsibilities documents. I can request copies. Elite DNA Therapy Services, LLC must post NPPs. Signed copies of consents, agreements, and authorizations can be used in place of original scanned into medical record chart.

By signing below, I am agreeing to consent for treatment and my understanding of the information described in this document. I have read this consent and have been able to ask questions.

_____ _____

Printed Name of Patient or Guardian Relationship to Patient

_____ _____

Signature of Patient or Guardian Date

Elite DNA Therapy Services, LLC

Permission to Discuss Protected Health Information (PHI)
Others Who are Involved in Your Healthcare

(Not to Be Used as Authorization to Release Information)

Patient Name: _____ Date of Birth: _____

I hereby permit Elite DNA Therapy Services, LLC to share specific information described below, only for the purposes and persons involved in my healthcare.

Description of the specific information to be discussed:

[ ] Appointment Date/Times [ ] Summary of Medical Record [ ] Pick Up Prescriptions
[ ] Diagnosis [ ] Care Plan [ ] Other (specify): _____
[ ] Medications Lab Tests/Results [ ] Genetic Testing Results

Indicate Confidential Information you **don't want discussed**:

[ ] Mental Health [ ] Medication [ ] HIV information [ ] Alcohol/Drug Information

Information provided to:

Full Name: _____ Full Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Relationship to Patient: _____ Relationship to Patient: _____

It is my responsibility to inform Elite DNA Therapy Services, LLC of changes and to revoke and complete another form.

I understand that:

- This document does not dictate that our providers will initiate conversations or other methods to share information with persons listed above. If those persons wished to be involved, then it is their duty to initiate involvement, and if time and circumstances permit, then Elite DNA Therapy Services, LLC will do our best to comply to your wishes.
- I may revoke this permission in writing by contacting our office manager or Privacy Officer.
- Information shared may be subject to re-disclosure by the recipient and no longer be protected under HIPAA.
- **This document is intended to relieve burden of our staff to know to whom you want to involve in this patient's care. It is not mandatory to complete.**
- **This document is not an authorization to release protected health information (PHI).**
- **Information Excluded from the Right of Access: Psychotherapy notes, which are the personal notes of a mental health care provider documenting or analyzing the contents of a counseling session, that are maintained separate from the rest of the patient's medical record. (45 CFR 164.524(a)(1)(i) and 164.501)**

_____ _____

Printed Name of Patient or Guardian Relationship to Patient

_____ _____

Signature of Patient or Guardian Date

Elite DNA Therapy Services, LLC

General Policies, Insurance Assignments, and Financial Agreement

Patient Name: _____ Date of Birth: _____

General Policies

_____ (initials) **Emergency Services –** Elite DNA Therapy Services, LLC is not a 24-clinic and WE DO NOT PROVIDE EMERGENCY SERVICES. For emergencies call 911 or go to nearest emergency room. For non-life-threatening after-hours services, please call the office and follow prompts.

_____ (initials) **Missed/Cancelled Appointments –** A patient who fails to appear or cancels less than 24 hours in advance of an appointment may be subject to a $40 fee and may be discharged. Please remember to reschedule ahead of time and we will attempt to accommodate your requests. Since "things happen," patients will be permitted to miss one appointment in a 6-month period without being penalized. However, please know that repeated "no-shows" may jeopardize your ability to receive treatment.

_____ (initials) **Lateness –** Due to stringent billing requirements, we will be unable to see patients who are late for their appointment. Please call to let us know if you are running late and we will attempt to reschedule your appointment, as needed. However, you may be subject to a $40 fee or suspension of services if you are not able to maintain your appointments.

_____ (initials) **Absence for More than 6 Months –** If you cancel or miss your appointments for longer than a 6-month period, you may be considered a new patient and another intake appointment may be necessary. Also, you may be placed on a waiting list.

_____ (initials) **Communications –** You understand that you may receive calls from Elite DNA Therapy Services, LLC or third-party business associates for purposes of including, but not limited to, results communication, patient surveys, and debt collection using the phone numbers, including wireless numbers you have provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

_____ (initials) **Confidentiality and Release of Protected Health Information (PHI) –** All information disclosed within sessions is confidential and may not be revealed to anyone outside of the Elite DNA Therapy Services, LLC without written permission, except for disclosures as required by law. The law does require clinicians to report to the authorities any reasonable suspicions of child or elder abuse, or danger of harm to self and/or to others unless protective measures are taken. To the extent necessary to determine insurance benefits or liability for payment and to obtain reimbursement, Elite DNA Therapy Services, LLC may disclose portions of the patient's medical record and account file to any person or corporation that may be liable for all or any portion of the patient's charges, including but not limited to insurance companies, health care service plans or workers' compensation carriers. Elite DNA Therapy Services, LLC may disclose information to referring provider following the minimum necessary rule.

Insurance Assignments

_____ (initials) **Fees for Clinical Services –** At Elite DNA Therapy Services LLC, we accept many insurance plans, single case agreements, and private pay. Please inquire about our fees, as the rates may be different depending on which provider you are seeing. Please know that you may be billed for telephone calls, written reports or other services that specifically require the provider's time outside of scheduled appointments.

_____ (initials) **Assignment of Insurance Benefits –** In consideration of services rendered, I hereby transfer and assign to Elite DNA Therapy Services, LLC all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance.

_____ (initials) **Medicare / Medicaid –** I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me may send to responsible carriers, or their intermediaries, any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treatment me.

Financial Agreement

_____ (initials) **Payment Responsibility –** I understand that insurance claims are filed as a courtesy. If a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the provider for services rendered to the patient. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges. I authorize direct payment to be made to Elite DNA Therapy Services, LLC for all services and treatments rendered. I understand if any services or treatments charges are not covered by my insurance carrier or my eligibility cannot be verified, I am responsible for all charges incurred. Furthermore, it is an agent or patient's responsibility to know insurance coverage for services, as some services and general medical coverage may be provided by two separate plans. I understand that it is my responsibility to pay any co-pay, deductible, co-insurance, or any other balance not paid for by insurance or third-party payor within a reasonable time not to exceed 30 days. If you are considered the guarantor, you will provide your name, Date of Birth, and Social Security Number to satisfy requirements to bill insurance companies. Our office staff is happy to help answer questions and help with this process.

_____ (initials) **Financial Agreement –** The signatory agrees, whether signatory signs as agent or as patient, that in consideration of services to be rendered to patient, signatory obligates them to pay charges for services received in accordance with regular rates and terms of Elite DNA Therapy Services, LLC. We reserve the right to assign unpaid bills to a collection agency. Should your account be referred to an attorney for collections, the signatory should pay reasonable attorney's fees and collection expense. If you have any questions about by this agreement, please feel free to ask for clarification.

The signatory certifies that he or she has read, understands, and accepts these terms and conditions of this document and is either the patient or is duly authorized by the patient as patient's general agent to execute the above agreement and may receive a copy upon request.

Printed Name of Patient or Guardian	Relationship to Patient
Signature of Patient or Guardian	Date

You have the right to request copies of all signed documents.

Patient's Bill of Rights and Responsibilities

Section 381.026, Florida Statutes

A patient has the right to:

- Be treated with courtesy and respect, with appreciation of his or her dignity, and with protection of privacy. Receive a prompt and reasonable response to questions and requests.
- Know who is providing medical services and is responsible for his or her care.
- Know what patient support services are available, including if an interpreter is available if the patient does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given full information and necessary counseling on the availability of known financial resources for care.
- Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare.
- Receive prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of an understandable itemized bill and, if requested, to have the charges explained.
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research.
- Express complaints regarding any violation of his or her rights.

A patient is responsible for:

- Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his or her health.
- Reporting unexpected changes in his or her condition to the health care provider.
- Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.
- Following the treatment plan recommended by the health care provider.
- Keeping appointments and, when unable to do so, notifying the health care provider or facility.
- His or her actions if treatment is refused or if the patient does not follow the health care provider's instructions.
- Making sure financial responsibilities are carried out.
- Following health care facility conduct rules and regulations.

Agency for Health Care Administration – Visit us at www.FloridaHealthFinder.gov

If you have questions or concerns, please contact our Privacy Officer.
Phone: 239.223.2751
Emal: Privacy@EliteDNATherapy.com
Hotline: 888.453.3114

Elite DNA Therapy Services, LLC
Notice of Privacy Practices

Purpose:
This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Our Commitment to Your Privacy
Our practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information (IIHI) or Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. At Elite DNA Therapy Services, the privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. Our practice will also post a copy in our office in a visible location always.

Understanding Your Health Record/Information
Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy
- Better understand who, what, when, where, and why others may access your health information
- Make more informed decisions when authorizing disclosure to others

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- Request to amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Right to A Copy of Your Medical Records
This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. To inspect and copy medical information that may be used to make decisions about you, you must contact the office to obtain an Authorization Form. Once you have received this form, please fill it out thoroughly and send the form back to the office.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed.

Right to Request Restrictions
You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Please discuss any restriction you wish to request with your physician. You may request a restriction by contacting the office for a "Request of Restrictions Form". This form must be submitted to our office.

Right to Amend
This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to obtain the "Health Record Amendment Form". This form must be submitted to our office.

Right to Receive Certain Accounting Disclosures
This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. Please contact our Privacy Officer to obtain the "Request for Accounting Disclosures Form". This form must be submitted to our office.

Right to Obtain A Paper Copy
You are entitled to receive a paper copy of our notice of privacy practices. To obtain a paper copy of this notice, please contact the Office.

Our Responsibilities
Elite DNA Therapy Services, LLC is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

How We May Use and Disclose Your Information Treatment
For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

Payment
For example: 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, as well as your diagnosis, procedures, and supplies used.

Healthcare Operations
For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates
There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Appointment Reminders
We may contact you by phone or leave a message on your home, work or cell phone as a reminder that you have an appointment scheduled for medical care at the office. Please notify us if you do not wish to be contacted for appointment reminders.

Notification
We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family Members
Health professionals, using their best judgment, may disclose to a family member, other relative, close friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Disclosures Required by Law
We may use or disclose your protected health information to the extent that the use or disclosure is required by federal, state, or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Military and National Security
When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation/Health Oversight Activities
Your Protected Health Information may be disclosed by us as authorized to comply with Workers' Compensation laws and other similar legally-established programs.

We may disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your medical information in response to a court or administrative order. We may also disclose your medical information in response to a subpoena.

Coroners, Medical Examiners and Funeral Directors
We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death.

Other Uses and Disclosures of Health Information
We will not use or disclose your Protected Health Information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization in writing at any time. If you revoke the Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. We cannot release you're your Psychotherapy Notes without a special signed, written authorization (different than the Authorization mentioned above) from you. To disclose these types of records for purposes of treatment, payment or health care operations, we will have to have a special written authorization that complies with the law.

Food and Drug Administration (FDA)
We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Correctional Institution
Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Complaints (Anonymous Hotline Number 888.453.3114)
There will be no retaliation for filing a complaint.

If have questions and would like additional information, you may contact our Privacy Officer at 239.223.2751

If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer at 239.223.2751 or privacy@elitednatherapy.com.

OR with the Secretary of Health and Human Services by using the information below:
Timothy Noonan, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD :(800) 537-7697
Email: ocrmail@hhs.gov

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