Welcome to our Compass Health Systems Family! Thank you for choosing us for your behavioral, medical, and wellness needs. Our mission is to provide the best possible patient care to every patient and help you reach your goals through our comprehensive services.

Before your first visit to Compass Health Systems (CHS), it is important you complete our New Patient Packet. This will allow us to expedite your first visit and inform you of all the services we provide.

Our clinical staff at Compass believe in a team oriented approach to your wellness plan, including integrated services, such as pharmacy, laboratory, specialists, and primary care physicians. MedzDirect, our pharmacy, provides your medication accurately, timely, and with provider oversight while providing special services such as free next day delivery. In addition, we have clinical research studies at Segal Institute for Clinical Research, providing you with additional care options. These added specialized services CHS offers allows us to give you the best personalized care possible.

We want you to enjoy your experience with CHS. To achieve this goal, we also offer a specialized patient portal (web), as well as Healow (app), which allow you to request appointments, make changes to your appointments, and view all information that pertains to your wellness plan. Please be advised along with this welcome email, you should also receive an email with instructions to log into our online patient portal, as well as another email with instructions to download the healow app. If you do not receive these emails, please check your Junk/Spam email folders and look for emails from "no-reply@eclinicalworks.com" or "Compass Health Systems". If you do not see these emails, please contact us to have them resent.

In addition, our most updated business hours and locations are located on our website, www.compasshealthsystems.com, or you can give us a call at (888) 85-COMPASS.

From all of us here at CHS, we thank you for choosing us as your solution for all your wellness needs. We look forward to seeing you for your first appointment!

Best Regards,

Dr. Scott Segal and the Compass Health Systems Family

COMPASS
HEALTH

Instructions for Completing your New Patient Packet

We want to make your first appointment as quick and as simple as possible. Our New Patient Packet can be easily filled out electronically. This will allow you to check-in for your first appointment with all the necessary paperwork already completed.

1) Complete all required sections, and as many additional sections as possible.

   **Please note that many of the information fields are auto-fill. For example, if you fill in your name in the first field, it will automatically fill in your name throughout the rest of the packet.*

2) Review and sign the policies related to your treatment.
3) Review and sign the applicable Advance Directive statement.
4) Click 'SUBMIT' to send your completed New Patient Packet to CHS. Your information will be uploaded to your patient profile.

You will be able to access your patient profile to review and update any information when necessary. You will also have access to interesting features related to your wellness plan.

Please remember to bring your Driver's License/ID and your Insurance Card(s) to your first appointment.

If you experience any issues or have any questions when completing your New Patient Packet, please call (888) 85-COMPASS, and we will help guide you through the process.

MEDZDIRECT Just what the doctor ordered

SEGAL Trials

COMPASS HEALTH

PATIENT INFORMATION

Name: _____ MI: _____

SSN: _____ DOB: _____ ☐ Minor

Gender: ○ M ○ F Primary Language: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Primary Phone: _____

Driver's License/ID #:_____

State: _____ Expiration: _____

CONTACT INFORMATION

Work Phone: _____

Home Phone: _____

Cell Phone: _____

PREFERRED CONTACT

○ Mail

○ Email

○ Primary Phone

○ Patient Portal

MARITAL STATUS

○ Single

○ Married

○ Divorced

○ Separated

○ Widowed

○ Life Partner

ETHNICITY

○ Hispanic or Latino

○ Other

○ Unreported/Refuse to Report

RACE

○ White

○ Asian

○ Hispanic or Latino

○ Unreported/Refuse

○ Other Race: _____

○ American Indian or Alaskan Native

○ Black or African American

○ Native Hawaiian or Other Pacific Islander

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____

Phone #: _____

HOW DID YOU HEAR ABOUT US?

○ Insurance

○ Hospital

○ Physician Referral

○ Online

○ Other _____

PREFERRED LANGUAGE

○ English

○ Spanish

○ Russian

○ Haitian Creole

○ Other _____

RESPONSIBLE PARTY/GUARANTOR/LEGAL GUARDIAN

☐ SAME AS PATIENT

Name: _____ MI: ____ DOB: _____ Relationship to Patient: _____

Address: _____ City: _____ State: ____ Zip: _____

Employer: _____ Occupation: _____

Phone: _____

Driver's License/ID#: _____ State: _____ Expiration: _____

Are you the legal guardian? ○ Yes ○ No **Please provide proper documentation**

Custodial Parent and Legal Guardian Attestation

Dear Parents:

State law requires you consent to most medical treatments for your minor child/ ward.

Regarding parents who are divorced, the term "shared custody" refers to shared physical living arrangements, and the term "joint custody" refers to **shared decision making**. Joint custody addresses issues that are fundamental to the children's life, such as religious upbringing, **medical care,** and education. Barring a hostile relationship between parents, the court expects them to make such decisions together.

To expedite your child's treatment, please be advised that Compass Health Systems requires parental attestation to provide services. Please be advised that your signature below obligates you to share details pertaining to your child's treatment with the child's other parent. Both parents are invited to attend the child's appointments. If the other parent is unable to attend appointments, they do have a right to access the child's medical records. Therapy notes are excluded from this access.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that, among other things, protects the privacy of individually identifiable health information. HIPAA's Privacy Rule generally allows a parent, as the minor child's representative, to access his child's medical records.

There are three situations in which a parent wouldn't be the minor child's personal representative under the Privacy Rule. The exceptions are:

1. When the minor is the one who consents to care and the consent of the parent isn't required under State or other applicable law
2. When the minor obtains care at the direction of a court or a person appointed by the court
3. When, and to the extent that, the parent agrees that the minor and the health care provider may have a confidential relationship (therapist)

Sole Custody

I _____ (**Signature** of Parent or Legal Guardian) hereby attest that I am the parent/legal guardian of (full legal name) _____and have sole and/or can provide medical decision making for my child/ward. Date: _____

Shared Custody

I _____ (**Signature** of Parent or Legal Guardian) share guardianship and agree to discuss all care provided with other parties involved in the care of my child/ward.

_____ (legal name). Date: _____

Please provide a copy of any custody agreement for the medical record.

COMPASS HEALTH

SOCIAL, EDUCATION, AND WORK HISTORY

Do you drink alcohol? ○ Yes ○ No How many drinks per week? _____

Are you a current smoker? ○ Yes ○ No How many packs per week? _____

Are you a former smoker? ○ Yes ○ No What year did you quit? _____

How many years of smoking? _____

Rate your average stress level: (1- least stress and 5- most stress): _____

SEXUAL HISTORY

Are you sexually active? ○ Yes ○ No

Do you have sex with: ○ Men ○ Women ○ Both

How many partners have you had during the past 12 months? _____

Are you concerned you may have been exposed to HIV? ○ Yes ○ No

EDUCATION INFORMATION

Highest Level: _____

School Attended: _____

OCCUPATIONAL INFORMATION

Current Occupation: _____

Work Related Stress: ○ Yes ○ No

HOBBIES

- ☐ Biking
- ☐ Running
- ☐ Reading
- ☐ Swimming
- ☐ Computer/TV
- ☐ Other:_____

EMPLOYMENT STATUS

- ○ Employed
- ○ Unemployed
- ○ Retired
- ○ Disabled
- ○ Current Student

FAMILY HISTORY

	N/A	Father	Mother	Siblings	Children
High Blood Pressure	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Cancer:_____	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Melanoma	☐	☐	☐	☐	☐
Diabetes:_____	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐
Mental Illness:_____	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Parkinson's Disease	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Unknown/Adopted	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐

COMPASS HEALTH

YOUR MEDICAL HISTORY (Fill in all that apply)

- ☐ **None**
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots
- ☐ Bronchitis
- ☐ Cancer (Type)_____
- ☐ Cerebrovascular Accident
- ☐ Coronary Artery Disease
- ☐ COPD (Emphysema)
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Frequent Infections
- ☐ Gallbladder Disease
- ☐ GERD (Reflux)
- ☐ GI Disorder
- ☐ Glaucoma
- ☐ Heart Attack (MI)
- ☐ Heart Palpitations
- ☐ Heart Murmur
- ☐ Hepatitis A, B, C
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Irritable Bowel Disease
- ☐ Lactose Intolerance
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Dis.
- ☐ Pneumonia
- ☐ Polycystic Ovarian Synd.
- ☐ Prostate Disease
- ☐ Renal (Kidney) Disease
- ☐ STD: _____
- ☐ Sexual Problems
- ☐ Shortness of Breath
- ☐ Thyroid Disease
- ☐ Uterine Fibroids
- ☐ Venereal Disease: _____

Dermatology History

- ☐ Rashes
- ☐ Lesions
- ☐ Skin Cancer
- ☐ Skin Melanoma
- ☐ Acne (Facial/Body)
- ☐ Wrinkles
- ☐ Age Spots
- ☐ Eczema
- ☐ Dryness

Neurological History

- ☐ Peripheral Neuropathy
- ☐ Tremors
- ☐ Difficulty Speaking
- ☐ Dizziness
- ☐ Migraines
- ☐ Light Sensitivity
- ☐ Nausea
- ☐ Weakness/Fainting
- ☐ Pain: _____
- ☐ Numbness/Tingling
- ☐ Seizures
- ☐ Spinal Injuries
- ☐ Epilepsy

Behavioral History

- ☐ Depression
- ☐ Memory Loss
- ☐ Hallucinations
- ☐ Loss of Interest/Pleasure
- ☐ Loss of Energy/Fatigue
- ☐ Weight Loss/Gain
- ☐ Insomnia
- ☐ Anxiety
- ☐ Drugs Use
- ☐ Alcohol Abuse
- ☐ Attention Problems

WOMEN

Are you pregnant? ○ Yes ○ No

Are you planning on being pregnant?

○ Yes ○ No

Are you lactating? ○ Yes ○ No

Are you currently on birth control pills?

○ Yes ○ No

Menstrual Problems? ○ Yes ○ No

Vaginal Infections? ○ Yes ○ No

☐ None ALLERGIES

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

☐ None HEALTH MAINTENANCE (Fill all that apply)

- ☐ Flu Vaccine
- ☐ Pneumonia Vaccine
- ☐ Tetanus Vaccine
- ☐ Hepatitis Vaccine
- ☐ Shingles Vaccine
- ☐ Gardasil Vaccine
- ☐ Mammogram
- ☐ PAP Test
- ☐ Physical Examination
- ☐ STD Examination
- ☐ EKG
- ☐ Heart Stress Test
- ☐ Ab Aneurysm Screen
- ☐ Colonoscopy

SURGERY/HOSPITILIZATION

☐ NONE Please list all prior surgeries and hospitalizations

Year:	Reason:
_____	_____
_____	_____
_____	_____
_____	_____

COMPASS HEALTH

MEDICATIONS, VITAMINS, & HERBAL SUPPLEMENTS

☐ I do not take any medications, vitamins, or herbal supplements

Medication	Dosage	Directions	Medication	Dosage	Directions
Example: *Tylenol*	*500 mg*	*1 pill twice daily*			

INSURANCE INFORMATION

☐ Check Here for Self-Pay

Please bring Insurance Card(s) and a valid Driver's License/ID to your first appointment

Patient Name: _____ DOB: _____ Employer Name: _____

Primary Insurance Co: _____Policy #: _____ Group #: _____

Insurance Co. Address: _____ Phone #: _____

Subscriber Name: _____ Relationship to Patient: _____ DOB: _____

Secondary Insurance Co: _____Policy #: _____ Group #: _____

Insurance Co. Address: _____ Phone #: _____

Subscriber Name: _____ Relationship to Patient: _____ DOB: _____

Worker's Compensation Co. Name: _____ Claim #: _____

Attorney Name: _____ Phone #: _____

Rx Insurance: Rx BTN: _____ Rx Group: _____ Rx PCN: _____

Member ID #: _____ Pharmacy Helpdesk #: _____

SEGAL Trials ☐ I allow Compass Health Systems to share my medical information with Segal Institute for Clinical Research for studies and clinical trial purposes.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO PRIMARY CARE PROVIDER (PCP)

This release will allow Compass Health Systems (CHS) to forward information regarding my current course of treatment for up to 60 days following the end of my treatment. Any revocation to this release will be notified to CHS in writing.

- ○ Check here if you prefer NOT to release your healthcare information to your PCP
- ○ I DO NOT have a PCP
- ○ I request and authorize Compass Health Systems to release my healthcare information to my PCP.

This request applies to: (Check all that apply)

○ All healthcare information ○ Treatment ○ Condition ○ Date _____ ○ Other _____

I authorize the release of any records as indicated by checkmarks above, regarding treatment of drugs, alcohol, or mental health services to my Primary Care Provider.

Parent/Guardian Signature: _____ Date: _____

PRIMARY CARE PHYSICIAN AND SPECIALISTS

At Compass Health Systems, our Primary Care Physicians (PCPs) take pride in the personal relationships we foster with our patients. We also provide a team of specialists that take care of many aspects of your wellness needs. Our team of doctors strive to achieve the highest level of patient satisfaction and provide convenient access to quality care. Join our family to receive the best possible patient care.
If you currently do not have a PCP, or are looking to change, please see our front desk to schedule an appointment, or give us a call at (888)-85-COMPASS.

Please list your PCP and other Physicians below

PCP Name: _____	Specialist Name: _____
Clinic Name: _____	Type of Specialty: _____
Address: _____	Clinic Name: _____
City:_____State_____Zip:_____	Address: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
Specialist Name: _____	Specialist Name: _____
Type of Specialty: _____	Type of Specialty: _____
Clinic Name: _____	Clinic Name: _____
Address: _____	Address: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

COMPASS HEALTH

MEDZDIRECT
Just what the doctor ordered

Can't stand having to wait in a pharmacy after your visit? We have an exclusive pharmacy just for you!

- ✓ Amazing Customer Service
- ✓ Integrated Doctor/Pharmacy Convenience
- ✓ Free Next-Day Delivery
- ✓ Price Matching

☐ I agree to use MedzDirect as my preferred pharmacy of choice.

YOUR PHARMACY INFORMATION

Name: _____ Phone: _____

Address: _____ Fax: _____

CREDIT CARD AUTHORIZATION FORM

I hereby authorize Compass Health Systems, MedzDirect, Compass Medical and Ingenious Personalized Medicine to charge my Credit Card as follows. I agree that this form will act as substitution for any UCC or other authorization form. I take full financial responsibility should any problems arise with the credit card company. I authorize Compass Health Systems, MedzDirect, Compass Medical and Ingenious Personalized Medicine to charge for any amounts not covered by my insurance including but not limited to, Co-Pay's, Deductibles, and for services and/or goods (products) not covered. I acknowledge that the details, terms, and conditions under which I am accepting services or purchasing services or goods from Compass Health Systems, MedzDirect, Compass Medical, and Ingenious Personalized Medicine have been explained to me in full.

Credit Card: (check one) ○ Master card ○ Visa ○ Amex ○ Discover

Credit Card Account Number: _____

Expiration Date: _____ Security Code: _____
Month Year

_____ _____
Print Your Name as Appears on Card | Signature as It Appears on Card (Required)

_____ _____
Billing Street Address | Billing City State Zip

_____ _____
Home Street Address (If different than billing address) | Home City State Zip

_____ _____
Home Telephone (Include Area Code) | Cell Phone Number (Including Area Code)

A copy of your Credit Card (front and back), as well as Driver's License will be made at your first visit.

AUTHORIZATION FOR TREATMENT

I hereby authorize treatment by Compass Health Systems (CHS) and have agreed to voluntarily receive such treatment. I consent to treatment and services deemed advisable by CHS clinicians including urine/saliva drug testing. I acknowledge that any questions I have regarding this treatment may be directed towards CHS clinicians or staff.

Patient Signature: _____ Date: _____

LIFETIME ASSIGNMENT *(MEDICARE PATIENTS ONLY)* AND COMMERCIAL INSURANCE AGREEMENT

Name of Beneficiary: _____ Medicare Number: _____

Health Insurance: _____

I request that payment of authorized Medicare benefits be made to Compass Health Systems for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine benefits payable for related services.

This authorization is in effect until I choose to revoke it.

I request that the payment for services rendered to me and my dependents by Compass Health Systems be made to Compass Health Systems for the year(s) that I received said treatment(s).

Patient Signature:_____ Date:_____

ADVANCE DIRECTIVE NOTIFICATION

I acknowledge I am being provided a copy of the Advance Directive, including Medical Durable Power of Attorney, Living Will, and DW-CPR for my state of residency.

Please Check One:

- ○ Patient is a minor in the state of residency.
- ○ I elect on my behalf not to execute an Advance Directive.
- ○ I have executed an Advance Directive previously, or will execute a new one, and will provide a copy to CHS to be placed in my chart.

Blank Advanced Directives for your state of residency are available on our website,

www.compasshealthsystems.com***, of in our office.***

Patient Signature:_____Date:_____

Office Use Only:
Copy of Advance Directive was received on:_____

FINANCIAL POLICY

Thank you for choosing Compass Health Systems as your health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy.

All clients must complete our information and financial policy form before seeing their clinician.

We bill your insurance as a courtesy. You are responsible for not only your deductible and co-payment, but also for any amounts for services not covered by insurance. If your insurance company has not paid your account in full within 90 days, you will be automatically billed for the entire balance and responsible for it. Please be aware that some, and perhaps all, of the services provided might not be covered or be unauthorized services not considered reasonable and necessary under your insurance guidelines.

- You are responsible for your portion of the bill at the time of service.
- We accept cash, checks, or VISA/MasterCard/American Express
- We offer an extended payment plan with preceding credit approval.

Maxed Benefits/Pre-Existing Conditions or Denials of Authorization for Treatment

During your treatment, your insurance benefits may be terminated for the year, for your lifetime, or further treatment may be denied authorization. In this event, you will be billed in full for each service thereafter. Please contact our office if there is any change in insurance policies or addresses/phones.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our clients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Direct Payments to Clients

If your insurance company reimburses you directly, **you are required to investigate these payments and turn them over to your health care provider immediately, or you will be required to pay for all services in full and terminated as a patient**. Keeping payments meant for your health care provider is a serious offense and can lead to legal proceedings.

Potential HMO Coverage

If your claim is denied for being on an HMO, you have not advised the office, and you did not obtain authorization for the services being rendered to you, then you are liable for the cost of these services and will be charged for them.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $25.00 per missed appointment. Please help us serve you better by keeping scheduled appointments, or call us 24 hours prior to your scheduled appointment to cancel or reschedule your appointment.

I Understand and Agree to this Financial Policy

Patient Signature:_____ Date: _____

MEDICATION AGREEMENT AND REFILL POLICY

As part of your treatment, our medical staff may prescribe medication(s) to you. As you know, medication(s) can have serious side effects if they are not managed properly. Your health and safety are very important to us, so we need your help to make sure your treatment follows approved guidelines. With your signature below, you are agreeing that you have read, understood and agreed with the following policies:

1. **I agree to keep all scheduled appointments** to ensure the receipt of my medication(s) on a timely basis. If you are unable to keep your appointment, you may be required to wait until the next available appointment to receive a refill. This will be determined on a case-by-case basis. I understand if I am more than fifteen (15) minutes late to my scheduled appointment, I may be required to reschedule for a different date and time.
2. I agree to follow the dosing schedule prescribed to me by my doctor. Should I have any questions or concerns regarding my prescribed medication(s), I will contact my provider. I will not make adjustments to the dosing schedule myself. I understand any such changes in medication, if made without the advice of a licensed physician could pose harm to my health.
3. I agree to notify **Compass Health Systems** if I experience any adverse effects or dosing problems with my prescribed medication(s). I may be asked to bring any unused medication to **Compass Health Systems** to ensure proper treatment adherence.
4. I understand that I should not drive or operate heavy machinery while I am taking medication(s) that may cause drowsiness or impair my cognitive functioning.
5. **Compass Health Systems** phone triage hours are from 8:00 am to 6:00 pm, Monday through Friday for Non-Emergency medication questions.
6. I understand that **Compass Health Systems** will provide controlled prescriptions once every thirty days. I must schedule another office visit within 30 days of the date on my current prescription so my doctor can properly evaluate my progress.
7. I agree that if I receive a controlled substance prescription from **Compass Health Systems**, I am not allowed to accept controlled substance prescriptions from any other physician without my provider's consent. I will give information regarding all my prescribed medication(s) to all providers who care for me, and will allow communication among these providers, per signed release(s) of information. I am aware that my controlled prescriptions can be monitored via a government website.
8. I agree to use only one pharmacy for my controlled medication(s). In the event that circumstances require the use of another pharmacy, I will notify **Compass Health Systems** of this immediately and provide them with all pertinent contact information.
9. **I understand that prescription refills involving controlled substances require a scheduled appointment with my provider. These medication(s) will not be called into your pharmacy or increased via phone.**
10. I understand that **Compass Health Systems** reserves the right to **PERFORM A URINE DRUG TOXICOLOGY SCREEN** on a random basis. This will be used to assess compliance with my prescribed treatment and/or gain insight into my habits, ensure no interactions occur among prescribed substances and those consumed, as well as to provide appropriate referrals and treatment alternatives when substance impairment becomes a concern.
11. I understand that in order to be prescribed my medication(s) on a regular basis, I will receive referrals for laboratory studies and will need to provide the results before the next office visit. Failure to do the required laboratory studies will result in delayed medication refills.
12. I understand that abusive behavior, abuse of medications, harassment toward any **Compass Health Systems Staff** or any of our patients will not be tolerated. **Compass Health Systems** will determine what actions are considered harassment or medication abuse on a case-by-case basis and, if warranted, can result in dismissal from the practice.
13. I understand that I am ***solely*** responsible for the safekeeping of my medication(s). I understand that **Compass Health Systems** does not replace **LOST OR STOLEN** prescriptions for controlled medication(s).
14. I will never share, sell, or exchange my medication(s) with anyone, for any reason.
15. I understand that involvement with a forged, falsified, or altered prescription will result in my immediate dismissal from **Compass Health Systems**, and/or police involvement.

I affirm that I have the full right and power to be bound by this agreement and that I have read, understood, and accepted these terms. Non-compliance with this agreement may be cause for dismissal from our practice.

Patient/Guardian Signature:_____ Date:_____

Printed Name:_____

HIPAA NOTICE OF PRIVACY PRACTICES (Revised: 1/2017)

Practice Locations: (888)-85-COMPASS

1601 N. Palm Ave., #211 Pembroke Pines, FL 33026	1065 NE 125th St., #206 North Miami, FL 33161	11440 N. Kendall Dr., #208 Miami, FL 33176	10301 Hagen Ranch Rd., #B6 Boynton Beach, FL 33437
7481 W Oakland Blvd., #100 Lauderhill, FL 33319	8671 S. Quebec St., #200 Highlands Ranch, CO 80130	6915 Tutt Blvd., #110B Colorado Springs, CO 80923	1483 Tobias Gadson Blvd., #107 Charleston, SC 29407

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.

This Notice of Privacy Practices describes how we my use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO), 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" is information about you, including demographic information, that may identify you and relates to your past, present, or future physical or mental health conditions and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of your office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by Law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (continued)

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization, and Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. 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.

You have the right to request a restriction of your protected health Information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also 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. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature: _____ Date: _____

Print Name: _____

****Any questions or concerns from patients pertaining to the protection of their privacy, please direct them to:**

Noralys Mallo, HIPAA Compliance Officer
Compass Health Systems, PA
1065 NE 125th Street, Ste 300
North Miami, FL 33161
Phone: (888) 85-COMPASS **Ext**. 2042 **Fax**: (305) 503-7363 **Email**: nmallo@compass.md

STATEMENT OF PATIENT'S RIGHTS

Patients have the right to:

- Be treated with dignity and respect.
- Fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability, sexual orientation, or source of payment.
- Have treatment and other patient information kept private. Only by Subpoena may records be released without their permission.
- Easily access care in a timely fashion.
- Know all about their treatment choices. This is regardless of cost or coverage by the patient's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- Have a clear explanation of their statement options.
- Get information about services and role in the treatment process.
- The clinical guidelines used in providing and managing their care.
- Information about a provider's work history and training.
- Provide input on policies and services.
- Information about laws that relate to their rights and responsibilities.

STATEMENT OF PATIENT'S RESPONSIBILITES

Patients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers the information they need. This is so providers can deliver the best possible care.
- Ask their providers questions about their care. This is so they can understand their role in that care.
- Follow treatment plans for their care. The plan of care is to be agreed upon by the patient and the provider
- Follow their agreed medication plan accordingly.
- Tell their provider about medication changes, including medications given to them by others.
- Keep their appointments or reschedule the visit. Patients should call their providers as soon as possible if they need to cancel or reschedule any visit(s).
- Let their provider know when the treatment plans no longer work for them, or requires updating.
- Let their provider or office manager know about problems with paying fees.
- Not take actions that could harm others.
- Report fraud or abuse.
- Openly report concerns about the quality of care.

Patient Signature: _____ Date: _____

WEB PATIENT PORTAL ACCESS

The Patient Health Portal provides a secure communication channel between you and your doctor's office. You can access your up-to-date medical records and lab results, track appointments, request refills of authorized prescriptions, referrals, and education materials. After submitting your New Patient Packet, you will receive an email with login information to access your Patient Health Portal.

Web Patient Health Portal:
https://health.healow.com/compass

To request an appointment with Compass Health Systems, you can download the quick and easy app healow™

Mobile APP Available at:

- Apple iOS App Store
- Android Google App Store

TELEHEALTH CONSENT FORM

Compass Health Systems Telehealth services involve the use of electronic communications to enable providers and patients for consultation, treatment planning, goals, evaluation, and medications through electronic media. Compass Health Systems providers are fully credentialed, and state licensed as applicable to the level of care they provide.

Contact Compass Health Systems Call Center 1-888-852-6672 for appointments, technical concerns; and access to other providers if technical services are interrupted.

The information used for diagnosis, therapy, follow-up and/or education, and may include any of the following: Client health records. live two-way audio and/or video, and/or output data from health devices and sound and video files

Compass Health Systems, Electronic Medical Systems (EMS), Telehealth platform is used to document medical record information maintaining network and software security protocols to protect the confidentiality of client identification and imaging data, and include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Expected Benefits: Benefits associated with the use of telehealth include and not limited to: Improved access to care by enabling a patient to remain under their provider's care from a 'home/safe' environment, continuity of care with efficient patient evaluation, treatment, management, and enabling Centers for Disease Control (CDC) protocols: and/or other public health measures.

Possible Risks: The potential risks associated with the use of telehealth include, and not limited to: In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images), delays in evaluation and treatment could occur due to deficiencies or failures of the equipment, in rare instances, security protocols could fail, causing a breach of privacy of personal health information; a lack of access to complete health records may result in interactions or allergic reactions or other judgment errors; and/or Telehealth may not be an adequate method of providing care under certain patient specific conditions that will require emergency intervention such as face-to-face services, referral to a hospital, enlisting other professionals or police to assist, and/or intervention to ensure patient safety and protection.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of health information also apply to telehealth, and that no information obtained in the use of telehealth will be disclosed without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction, and, may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of health care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
5. I understand that telehealth may involve electronic communication of my personal health information to other practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
8. I understand that if my care and treatment is deemed an emergency, danger to self or others, or for any other criteria; that emergency response procedures may be utilized that includes and is not limited to face-to face services, the referral to a hospital, the use of other professionals, or any other intervention the provider deems necessary for my safety and protection.

Patient Consent to the Use of Telehealth

I, _____(*Print First Name Last Name,)* have read and understand the information provided above regarding telehealth, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my care.

_____ _____

Patient/Guardian Signature: Date: