



Child Registration Form

This form can be used for all children UNDER the AGE of 18

Please complete this form to ensure proper billing of your services. **Please Print.**

Today's Date: _____

☒ New Patient ☐ Edit Information

Patient Information

Patient Last Name _____ First _____ MI _____

Preferred Name: _____ Date of Birth _____

Minor's Cell Phone _____

Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

☐ Declined to specify

Race:

☐ American Indian/Alaska Native ☐ Asian

☐ African American ☐ Native Hawaiian/Pacific Islander

☐ White ☐ Declined to specify

Preferred Language: ☐ English ☐ Spanish ☐ Other _____ **Translator?** ☐ YES ☐ NO Comments: _____

Patient's Primary Address

Address: _____

City, State, Zip: _____

Home Phone: (_____) _____

Patient's Reminders/Communication

This section is relative to preferred method of communication and Patient Portal access

Please provide the contact information for the person who is to receive the reminders/communication for this patient.

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

☐ Web Enabled E-Mail: _____
(must be patient's personal email if over age 18)

☐ No Email ☐ Patient Refused

☐ Voice Enabled Messaging ☐ English ☐ Spanish

Preferred method: ☐ Home ☐ Cell ☐ Work

☐ Text Enabled Messaging ☐ English ☐ Spanish

Preferred method: ☐ Home ☐ Cell ☐ Work

Types of reminders you wish to receive:

☐ Appointments ☐ Lab results ☐ Health Maintenance ☐ RX Confirmation ☐ General ☐ ALL ☐ NONE

Preferred Pharmacy Information

Primary Pharmacy Name, Address & Phone #: _____

Patient's Parental Information

Patient lives with ☐ Both Parents ☐ Mom ☐ Dad ☐ Guardian*
Custody Agreement ☐ YES ☐ NO ☐ N/A (If YES, please provide copy)

Mother's Name: _____

Cell Phone: _____

Mother Address same as patient ☐ YES ☐ NO

If NO- please complete

Addr: _____

City, State, Zip: _____

Mother's Date of Birth: _____

Home phone: _____

Email Address: _____

Employment Status:

☐ Employed FT ☐ Employed PT ☐ Not Employed

☐ Self ☐ Active Military ☐ Retired ☐ Reserved - Nat'l assignmt

Employer: _____

Other please explain: _____

*If YES to Guardian, please provide court documents

Father's Name: _____

Cell Phone: _____

Father Address same as patient ☐ YES ☐ NO

If NO- please complete

Addr: _____

City, State, Zip: _____

Father's Date of Birth: _____

Home phone: _____

Email Address: _____

Employment Status:

☐ Employed FT ☐ Employed PT ☐ Not Employed

☐ Self ☐ Active Military ☐ Retired ☐ Reserved - Nat'l assignmt

Employer: _____

Emergency Contact Information

(please provide contact other than parents)

Last Name, First Name: _____ Relationship to Patient: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Insurance Information

Please provide a copy of ALL Insurance cards

Please let us know if this is a ☐ Worker's Comp Issue ☐ MVA ☐ Legal Case ☐ School Insurance

☐ Self-Pay (no insurance) Patient insured under: ☐ Mother's Insurance ☐ Father's Insurance ☐ Other

☐ Medicaid – ID Number: _____

PRIMARY INSURANCE NAME:

Benefit Plan Name _____

Member ID: _____ Group#: _____ Effective Date: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify

PCP listed on card: _____

SECONDARY INSURANCE NAME:

Benefit Plan Name _____

Member ID: _____ Group#: _____ Effective Date: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify

PCP listed on card: _____

Guarantor Information

Guarantor must initial to acknowledge that you are aware that you will receive the bill and be financially responsible for this patient.

Guarantor Initial: _____

Relationship: ☐ Father ☐ Mother ☐ Other (specify): _____

Last Name: _____ First Name: _____

Date of Birth: _____ Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify

Address: _____

City, State, Zip: _____

Home phone: _____ Cell Phone: _____ Email: _____

Guarantor's Employer: _____

Work phone: _____

Address: _____

City, State, Zip: _____

Medical History

Date _____

Name _____	Age _____	Birthdate _____
Address _____	Sex ☐ Male ☐ Female	
_____	Home Phone _____	
_____	Work Phone _____	
Occupation _____	Emergency Contact _____	
	Phone _____	
☐ Single	☐ Married	☐ Divorced
	☐ Widowed	☐ Separated
If married, spouse's name _____		
Children's names and ages _____		

Allergies to Medications, X-Rays, Dyes, or Other Substances ☐ No ☐ Yes
(If yes, please list name of medicine and type of reaction)

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

Past Medical History and Review of Systems
Please check if **you** have had any problems with or are presently experiencing any of the following:

☐ High Blood Pressure	☐ Bronchitis	☐ Change in bowel habits	☐ Arthritis
☐ Diabetes	☐ Pneumonia	☐ Unexplained weight gain / loss	☐ Low back problems
☐ Cancer	☐ Persistent cough	☐ Hemorrhoids	☐ Skin diseases
☐ Heart Disease	☐ T.B.	☐ Gallbladder disease	☐ Blood disorders
☐ Chest pain / chest tightness	☐ Hay fever	☐ Colitis	☐ Venereal diseases
☐ Shortness of breath	☐ Abdominal discomfort	☐ Hepatitis or jaundice	☐ Anxiety
☐ Swollen ankles	☐ Indigestion	☐ Thyroid disease	☐ Depression
☐ Palpitations	☐ Nausea	☐ Head or neck radiation	☐ Anemia
☐ Lightheadedness	☐ Vomiting	☐ Headache	☐ Alcohol abuse
☐ Frequent urination	☐ Constipation	☐ Kidney disease	☐ Drug abuse
☐ Rheumatic fever	☐ Diarrhea	☐ Kidney stones	☐ Gout
☐ Asthma	☐ Blood in stool	☐ Difficulty urinating	☐ Impotence or Erectile Dysfunction
	☐ Ulcers		☐ Other

Gynecologic and Obstetric History

Age at onset of periods _____	Frequency _____	Length of period _____
Pregnancies _____	Births _____	Miscarriages _____
Prolonged or abnormal bleeding	☐ No ☐ Yes (Please describe)	_____
Leakage of urine	☐ No ☐ Yes (Please describe)	_____
Pelvic pain	☐ No ☐ Yes (Please describe)	_____
Abnormal discharge	☐ No ☐ Yes (Please describe)	_____
History of abnormal Pap smear	☐ No ☐ Yes (Please describe)	_____

This information is for use by your physician as part of your confidential medical record.

Please continue on the next page

Medical History

Name _____ Date _____

Please List and Supply the Dates of:

Operations _____

Hospitalizations other than for surgery: _____

Immunization history – have you had: Pneumovax immunization? ☐ No ☐ Yes When? _____

Hepatitis B? ☐ No ☐ Yes When? _____ Flu immunization? ☐ No ☐ Yes When? _____

Other ☐ No ☐ Yes When? _____ Tetanus immunization? ☐ No ☐ Yes When? _____

When was your last:

Pap smear? _____ Breast exam? _____ Colon cancer test? _____

Mammogram? _____ Cholesterol check? _____ Prostate exam? _____

Family History Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Age when diagnosed?
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental disease (anxiety, depression, etc.)	_____	_____
Drug or alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding diseases	_____	_____
Other _____	_____	_____

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Prevention

Do you wear seat belts? ☐ Yes ☐ No If no, why not? _____

Do you wear a bike helmet? ☐ Yes ☐ No ☐ N/A

Do you exercise regularly? ☐ Yes ☐ No If yes, type, duration and number of times per week? _____

Do you smoke? ☐ No ☐ Yes If yes, how many packs per day? _____

Do you drink alcoholic beverages? ☐ No ☐ Yes If yes, how much per week? _____

Do you drink coffee? ☐ No ☐ Yes If yes, how many cups per day? _____

Do you drink tea? ☐ No ☐ Yes If yes, how many cups per day? _____

If there is a gun in your home, do you keep it unloaded and out of children's reach? ☐ Yes ☐ No ☐ N/A

Do you use drugs? (marijuana, cocaine, crack, etc.) ☐ No ☐ Yes If yes, explain: _____

Have you ever engaged in any activity which has put you at risk of getting AIDS? ☐ No ☐ Yes If yes, explain: _____

Do you wish to be tested for AIDS? ☐ No ☐ Yes

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? ☐ No ☐ Yes If yes, explain: _____

Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? ☐ No ☐ Yes

Do you ever feel afraid of your partner? ☐ No ☐ Yes ☐ N/A

Do you have a "living will"? ☐ Yes ☐ No

Do you have a donor card? ☐ Yes ☐ No

Method of birth control? _____

This information is for use by your physician as part of your confidential medical record.



Annual Consent and Acknowledgment Form

This form is to be completed annually for Advocare LLC and scanned into each Patient's File

Patient Name: _____ DOB: _____

Address: _____

As used in this form, the words "I," "me," "my" and similar references means the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

Advocare and its parent, affiliates, associates, agents, services, debt collectors, independent contractors, assigns, successors, subsidiaries and employees (defined here collectively as "ADVOCARE" and referred to as "ADVOCARE" or "we") provide healthcare services (referred to collectively as the "Services"). By using the Services or accessing your account, any recipient of the Services accepts and also agrees to be legally bound by the terms of this Agreement to the extent permitted by law.

General Consent for Examination and Treatment

I hereby consent and authorize Advocare and all its physicians and ancillary medical personnel to perform medical examinations and provide routine medical care for all my visits. This may include routine diagnostic and laboratory procedures and tests, medication administration and other routine care for which my specific informed consent is not otherwise required. This consent includes consent and authorization to photograph or otherwise take images of me for purposes of identification, diagnosis, treatment, payment and healthcare operations. Any photographs or other images taken will become part of my medical record. Advocare will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that Advocare will provide me with information and forms prior to such procedures.

Acknowledgment of Receipt of Notice of Privacy Practices

I have been offered a copy of Advocare's Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that Advocare has the right to change its Notice of Privacy Practices from time to time and that whenever an important change is made, Advocare will post a new notice in its offices. I may contact Advocare at any time to obtain a current copy of the Notice of Privacy Practices. I may also access a copy on the Advocare website at www.advocaredoctors.com

Assignment of Benefits/Authorization/Notice of Collection

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles and charges denied by my insurance company as not covered or not medically necessary. You agree to reimburse Advocare the fees of any collection agency, which may be based on a percentage at a maximum of 40% of the debt added to the debt at the time it is placed with the agency for collection, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Consent to Contact

You expressly authorize, and specifically consent to allowing, ADVOCARE and/or its outside collection agencies, outside counsel, or any other agents acting by or on behalf of ADVOCARE to contact you or any recipient of the Services with informational messages regarding your account, including but not limited to contact in connection with any and all matters relating to unpaid past due charges billed to you. You agree that such contact may be made to any mailing address, telephone number, cellular phone number, e-mail address, or any other electronic address that you or a recipient of the Services have provided, or may in the future provide, to ADVOCARE and to any and all telephone numbers billed on your account or any number where you or a recipient of the Services can be reached by ADVOCARE. You expressly consent and agree that such contact may be made using, among other methods, pre-recorded, artificial voice, or other message delivered by any type of telephone equipment including a dialer, automatic telephone dialing system, predictive dialer, interactive voice recognition system, or text message delivered by an automated system, pre-set e-mail messages delivered by an automatic e-mailing system, or any other pre-set electronic messages delivered by any other automatic electronic messaging system, including numbers assigned to any paging, cellular or mobile service, even for any service for which you are charged for the call or contact. Carrier message and data rates may apply. You agree to provide true, accurate, current and complete contact information about yourself and any recipient of the Services to ADVOCARE and its authorized agents and to promptly update this contact information to keep it true, accurate and complete. If you do not want ADVOCARE to use these telephone contact methods to reach you or a recipient of the Services, please contact us at 856.221.2700 to discuss how we may communicate about this account

Vaccine Registry (if applicable)

Our office submits confidential data of children and adult vaccinations to your state's Immunization Registry as permitted by state law. The purpose of this registry is to keep a central record of patients' immunization history.

Disclosures to Authorized Individuals

I designate the following person(s) listed below as a person(s) involved with my medical treatment and/or payment for my medical treatment. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to your office address. A copy of the authorization may be used with the same effectiveness as the original. This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Name: _____ Relationship: _____

Address: _____ Phone: _____

Medical Treatment Information: Yes No

Payment Information: Yes No

Name: _____ Relationship: _____

Address: _____ Phone: _____

Medical Treatment Information: Yes No

Payment Information: Yes No

Please complete this section if the patient is covered by Medicare

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed? ☐ Y ☐ N Has treatment been authorized by the V.A.? ☐ Y ☐ N

Do you or your spouse have other insurance? ☐ Y ☐ N Are you covered under the Black Lung Program? ☐ Y ☐ N

Are you disabled or have end stage renal disease? ☐ Y ☐ N Is there Medigap coverage secondary to Medicare? ☐ Y ☐ N

Is illness/injury the result of an auto accident? ☐ Y ☐ N Is there insurance coverage primary to Medicare? ☐ Y ☐ N

Did illness/injury occur at work? ☐ Y ☐ N Is there employer supplemental coverage secondary to Medicare? ☐ Y ☐ N

Consent and Authorization

A copy of this consent and acknowledgment may be used in place of the original. I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my PHI and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document:

Patient Name: _____ Date: _____

Patient Signature: _____

Legal Representative (if other than patient) Print Name: _____ Date: _____

Legal Representative Signature: _____ Relationship to Patient: _____



Notice to Patient: Right to an Observer

You have the right to have an **observer** in the exam room during breast, pelvic, genital, and rectal exams performed by any doctor, physician assistant, or midwife.

An observer is a person who is trained to know what to expect and to watch a provider during these exams. The observer can help make sure you are not touched in a way that you shouldn't be.

If you want an observer, please ask for one. Remember, you can stop the exam at any time and for any reason.

If the office is unable to provide an observer, or if you are not comfortable with the observer that is offered, you can decide not to have the exam today. It can be canceled or rescheduled to another day/time. If that happens, your provider must give you a referral to another health care provider, if available. You can also choose to go ahead with the exam without an observer or go ahead with other parts of your visit that don't include or require the exam. It is your choice to make.

If you have any concerns or complaints about your exam, we encourage you to speak with your provider or the observer about these concerns.

The New Jersey Division of Consumer Affairs licenses doctors, physicians' assistants, midwives, and other health care providers. You can file a complaint with the Division of Consumer Affairs if you have any concerns or complaints about your exam. More information about filing a complaint is available at: <https://www.njconsumeraffairs.gov/sexual-misconduct-complaint>

If you have any questions, or do not understand this notice, please ask your provider.

By signing below, you show that you have read and understood this notice.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

Legal Representative, if other than patient (Print Name): _____

Relationship to Patient: _____

Legal Representative Signature: _____

Date: _____



Authorization for Use/Disclosure of Protected Health Information

I hereby authorize the use or disclosure of my individually identifiable protected health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Information

(Please Print):

Patient Name: _____ Date of birth: _____

Address: _____
(Street Address) (City) (State) (ZIP)

Phone Number: _____

I authorize (Sending Provider):

Provider/Facility Name

Street Address

City, State, ZIP

Phone Number

To release to (Recipient):

Advocare: Columbus Family Physicians

Recipient of records

23659 Columbus Road, Suite 4

Street Address

Columbus, NJ 08022-1980

City, State, ZIP

609-298-3304

Phone Number

888-830-1075

Fax Number

Send via mail or

Fax

Purpose for the record request:

Continued Care

Transfer of Care

Patient Request

Other (please specify): **New PCP**

Covering the period(s) of health care: From: _____ To: _____

Select from the following the information to be disclosed

(check all that apply):

- ☐ Abstract Record (Last year of encounters and procedures, lab results, and diagnostic results)
- ☒ Complete Medical Record (All records available for the dates requested above)
- ☐ Immunization Record
- ☐ Growth Charts
- ☐ Encounters
- ☐ Lab Reports
- ☐ Diagnostic Imaging Reports
- ☐ Photographs, videotapes, digital or other images
- ☐ Operative/Procedure Reports
- ☐ Consultation Reports
- ☐ Cardiology/EKG Report
- ☐ Itemized Billing Statements
- ☐ Other (please specify): _____

I authorize the following information to be included

(See reference guide bottom of Page 2) Please select:

- ☒ Mental health care or services
- ☒ Treatment for alcohol and/or drug abuse
- ☒ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection
- ☒ Reproductive Services

By signing this form, the Patient or Patient’s Legal Representative attests to reading and accepting the following statements:

1. I understand that unless earlier revoked, this authorization expires on ____/____/20____ or on the happening of _____.
- (If no expiration date is designated, this authorization will expire in 90 days from the signature date.)
2. I understand that I may revoke this Authorization at any time by notifying Advocare, LLC, in writing, but if I do so my revocation will not have any effect on any actions Advocare, LLC, took in reliance on this Authorization before it received my revocation.
3. I understand that Advocare, LLC, cannot make me sign this Authorization as a condition to receive treatment from Advocare, LLC:

i. When Advocare, LLC, provides me with research related treatment; or

ii. When Advocare, LLC, provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.
4. I understand and accept that by law you have 30 days to comply with my request.

Advocare, LLC, its providers, employees, members, and agents are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
(Form MUST be completed before signing)

Signature of Patient or Legal Representative: _____

Print Name: _____ Dated: _____

If Signed by Legal Representative, state relationship to patient: _____

Note: If you are the Patient’s Legal Guardian other than a parent, or if you are the Patient’s Power of Attorney, a copy of the legal document granting you such power must be attached to this request.

Reference Guide	
Mental healthcare or services	Psychiatric or psychological information, including any psychiatric or psychological treatment given by my provider.
Treatment for alcohol and/or drug abuse	Drug or alcohol information, including any drug or alcohol treatment or tests ordered by my provider.
AIDS or HIV infection	AIDS or HIV related information, including any AIDS or HIV-related treatment or tests ordered or by my provider.
Reproductive Services	All medical, surgical, counseling, or referral services relating to the human reproductive system including, but not limited to, services relating to pregnancy, contraception, or termination of a pregnancy. (Reproductive Law P.L.2022, c.51)

AS REQUIRED BY THE PRIVACY REGULATIONS CREATED UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA"), THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU (AS AN ADVOCARE PATIENT) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. Our Commitment to Your Privacy. Advocare, LLC and each of its Care Centers (collectively "Advocare") is dedicated to maintaining the privacy of your Protected Health Information ("PHI"). Protected Health Information is information about you, including demographic information, which may identify you and which relates to your past, present or future physical or mental health or condition, the provision of health care to you, or payment for your health care. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of PHI which identifies you. This Notice of Privacy Practices (this "Notice") describes how we may use and disclose your PHI to carry out treatment, payment and health care operations and for other purposes which are permitted or required by law. It also describes your rights to access and control your PHI. We reserve the right to revise or amend this Notice. Any revision or amendment to this Notice will be effective from a date of revision or amendment forward. Each Care Center will post a copy of our current Notice in a visible location at all times, and you may request a current copy at any time. You may also review a copy on our website at <https://www.advocaredoctors.com>.

B. How We May Use and Disclose Your PHI. The following are examples of the types of uses and disclosures of your PHI by Advocare.

1. These uses and disclosures are permitted under HIPAA and other applicable laws and regulations and may be made without your specific written authorization:

- a. Treatment:** We will use and disclose your PHI to provide, coordinate and manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we may disclose your PHI to another physician who may be treating you or to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may ask you to have laboratory tests (such as blood or urine tests), and we may receive and use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you.
- b. Payment:** Advocare may use and disclose your PHI in order to bill and collect payment for the services and items you receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits) and we may provide your insurer with details regarding your treatment to determine if your insurer will cover or pay for your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs (such as family members) or to other health care entities and collection agencies engaged for billing and collection efforts.
- c. Health Care Operations:** Advocare may use and disclose your PHI to operate our business. For example, Advocare may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for Advocare. We may disclose your PHI to other health care providers and entities to assist in their health care operations. We will share your PHI with third party "business associates" that perform various activities (for example, billing or transcription services) for Advocare. Whenever an arrangement between Advocare and a business associate involves the use or disclosure of your PHI, we will have a written contract which contains terms to protect your PHI's privacy.
- d. Public Health Activities:** We may disclose PHI to report information about births, deaths, various diseases, adverse events and product defects to government officials in charge of collecting such information; to prevent, control, or report disease, injury or disability as permitted by law; to conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- e. Health Oversight:** We may disclose your PHI to a health oversight agency for activities authorized by law. For example, we may disclose PHI to assist the government or other health oversight agency with activities including audits; civil, administrative or criminal investigations, proceedings or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
- f. Legal Proceedings:** We may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

g. Law Enforcement/Criminal Activity: We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. For example, we may disclose PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; or for the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

h. Coroners, Funeral Directors and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining a cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. We may disclose such information in reasonable anticipation of death. PHI may also be used and disclosed for cadaveric organ, eye or tissue donation purposes.

i. Research: Research is defined as a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge. In limited circumstances, we may use or disclose PHI to conduct medical research.

j. Military Activity and National Security: If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authority, we may use or disclose PHI for activities deemed necessary by appropriate military command authorities; for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to federal officials for intelligence and national security activities authorized by law.

k. Workers' Compensation: We may disclose your PHI as authorized to comply with workers' compensation laws and other similar legally-established programs.

l. Inmates: We may use or disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary for the institution to provide health care services to you; for the safety and security of the institution; and/or to protect your health and safety or the health and safety of other individuals.

m. To Avoid Harm: In order to avoid a serious threat to the health or safety of you, another person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

n. Appointment Reminders and Health-Related Benefits or Services: We may use and disclose PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer. Please let us know if you do not wish to have us contact you for these purposes, or you would rather we contact you at an alternate telephone number or address.

o. Childhood Immunizations: We may disclose an immunizations list to schools required to obtain proof of immunization prior to admitting the student, so long as we have obtained and documented the patient's or patient's legal representative's "informal agreement" to the disclosure.

p. Decedents: In certain circumstances, we may disclose PHI about a decedent to family and others involved in the decedent's health care or payment for health care. Other disclosures may require written authorization from the executor or administrator of the decedent's estate.

2. The following are additional examples of the types of uses and disclosures of your PHI which are permitted under HIPAA but require you to have an opportunity to object or agree prior to the disclosure.

a. Others Involved in your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI which directly relates to that person's involvement in your health care or payment for your health care. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person who is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family members or other individuals involved in your health care.

b. Health Information Exchange/Patient Portal: Consistent with federal law, Advocare participates in the following Health Information Exchanges and/or e-prescribing health networks (collectively, "HIE(s)): (i) New Jersey Health Information Network; (ii) CommonWell Health Alliance; (iii) CareQuality; (iv) SureScripts Network Alliance; and (v) other HIEs in which Advocare may determine to participate, in its discretion, from time to time. The purpose of an HIE is to provide an electronic information system through which physicians, healthcare facilities, pharmacies and other healthcare providers authorized to participate in the HIE (collectively, "Healthcare Providers") can share PHI electronically in connection with their provision of healthcare services to patients, thereby improving the overall quality of health care services provided to patients and to avoid duplication and inefficiencies. HIEs are governed by a strict set of rules designed to protect patient confidentiality and the privacy and security of patient information. Advocare electronically shares your PHI with the HIE, including information regarding sensitive diagnoses (such as HIV/AIDS, sexually transmitted diseases, genetic information, and mental health substance abuse). This Notice describes how Advocare and other Healthcare Providers can electronically access and use your PHI if needed to provide treatment to you, may use and disclose your PHI through the HIE and how you may "Opt-Out" (as described below) from having your information automatically shared through the HIE. For example, if you receive a blood test result from Advocare and also receive care from another Healthcare Provider (who also participates in the HIE), Advocare and your other treating Healthcare Provider can share your blood test result electronically through the HIE, as long as they are otherwise authorized to do so. However, if you Opt-Out (as described below), your PHI will not be made electronically available through the HIE, but will continue to be used, accessed and disclosed/released by Advocare as needed (in accordance with this Notice and applicable law).

If you do not wish to allow Healthcare Providers involved with your care to electronically share your PHI with one another through the HIE as explained in this Notice, you must submit an "HIE Opt-Out Form" to Advocare. You may obtain an "HIE Opt-Out Form" from your Advocare Care Center or by visiting the following website: <https://www.advocaredoctors.com>. Your Opt-Out request will be processed within three (3) business days of receipt by Advocare. In addition, Advocare maintains a patient portal through eClinicalWorks, a secure online tool which permits patients to view their PHI through a secure, encrypted portal from the Advocare home webpage. See also Section C.7 below.

3. The following are examples of the types of uses and disclosures of your PHI which are permitted under HIPAA but require your written authorization for use and disclosure.

a. Marketing Communications: We will obtain your written authorization prior to using or disclosing your PHI for marketing purposes. However, we are permitted to provide you with marketing materials in a face-to-face encounter, without obtaining a marketing authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining a marketing authorization. In addition, as long as we are not paid to do so, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. We may use or disclose PHI to identify health-related services and products which may be beneficial to your health and then contact you about the services and products.

b. Sale of PHI: We will disclose your PHI in a manner which constitutes a sale only upon receiving your prior authorization. Sale of PHI does not include a PHI disclosure for public health purposes, research, treatment and payment purposes, or the sale, transfer, merger or consolidation of all or part of our business and for related due diligence activities, as required by law, or for any other purpose permitted by and in accordance with HIPAA.

Other than as stated in this Notice, or if you have authorized Advocare to use or disclose your PHI for any other purposes, we will not use and disclose your PHI without your written authorization. You may revoke your authorization in writing at any time except to the extent Advocare acted in reliance on the authorization, or, if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

C. Your Privacy Rights. You have the following rights regarding the PHI we maintain about you:

1. Inspect and Copy: In most cases, you have the right to look at or get copies of your PHI which we maintain, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within thirty (30) days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you in writing our reasons for the denial

and explain your right to have the denial reviewed when applicable. If you request a copy of your information, we may charge you reasonable fees for the costs of copying, mailing or other costs incurred by us in complying with your request. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance. You have the right to access your PHI in an electronic format (to the extent we maintain the information in such a format) and to direct us to send the e-record directly to a third party. We may charge for the labor costs to transfer the information and charge for the costs of electronic media if you request that we provide you with such media. Please note: If you are the parent or legal guardian of a minor, certain portions of the minor's records may not be accessible to you. For example, records relating to care and treatment to which the minor is permitted to consent himself/herself (without your consent) may be restricted unless the minor patient provides an authorization for such disclosure.

2. Request a Restriction: You may ask us, in writing, not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. We will consider your request, but we are not legally required to accept it, except in the following circumstance. You have the right to ask us to restrict the disclosure of your PHI to your health plan for a service we provide to you where you have directly paid us (out of pocket, in full) for that service, in which case we are required to honor your request. If we accept your request for a restriction, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate our agreement to a restriction.

3. Confidential Communications: You have the right to request that Advocare communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you by telephone at home, rather than work, or at a particular address. We must agree to your request so long as we can easily abide by it in the manner you requested.

4. Amendment: You have the right to request an amendment to your PHI for as long as Advocare maintains it. You must make your request for amendment of your PHI in writing to Advocare, including your reason to support the requested amendment. Advocare will deny your request for amendment if (i) Advocare did not create the information; (ii) the information is not part of the designated record set; (iii) the information would not be available for your inspection (due to its condition or nature), or (iv) the information is accurate and complete. If Advocare denies your request for changes in your PHI, Advocare will notify you in writing with the reason for the denial. Advocare will also inform you of your right to submit a written statement disagreeing with the denial. You may ask that Advocare include your request for amendment and the denial any time that Advocare subsequently discloses the information that you wanted changed. Advocare may prepare a rebuttal to your statement of disagreement and will provide you with a copy of that rebuttal.

5. Accounting of Disclosures: You have a right to receive an accounting of the disclosures of your PHI which Advocare has made, except for the following disclosures: (i) to carry out treatment, payment or health care operations; (ii) to you; (iii) to persons involved in your care; (iv) for national security or intelligence purposes; or (v) to correctional institutions or law enforcement officials. You must make your request for an accounting of disclosures of your PHI in writing to Advocare. You must include the time period of the accounting, which may not be longer than six (6) years. In any given twelve (12) month period, Advocare will provide you with an accounting of the disclosures of your PHI at no charge. Any additional requests for an accounting within that time period will be subject to a reasonable fee for preparing the accounting.

6. The Right to Receive this Notice by E-Mail: You have the right to get a copy of this Notice by e-mail. Even if you have agreed to receive notice by e-mail, you also have the right to request a paper copy of this Notice.

7. "Opt-Out" of HIE: As described in Section B.2.b above.

8. Breach of PHI: Advocare will notify individuals following a breach of their unsecured PHI. A breach means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted under HIPAA and that compromises the security or privacy of the PHI.

D. How to Complain About Our Privacy Practices. If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the Advocare Privacy Officer listed below. You also may send a written complaint to the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint about our privacy practices. If you have any questions about this Notice or any complaints about our privacy practices, please contact our Privacy Officer at:

Director of Compliance, Audit and Privacy
Advocare, LLC
Lake Center Executive Park
401 Route 73 North, Building 10, Suite 320
Marlton, NJ 08053
Telephone: 856.872.7055

WE WILL NEED A
COPY OF YOUR
INSURANCE CARD
WHEN THE PACKET
IS RETURNED TO
OUR OFFICE.
PLEASE MAKE
SURE TO BRING IT
WITH YOU.