PREMIER
TOTAL HEALTHCARE

AUTO ACCIDENT QUESTIONNAIRE

FIRST NAME _____ LAST NAME _____ DOB _____ SEX M ___ F ____

ADDRESS _____ Apt# ____ CITY _____ STATE ____ ZIP _____

PHONE NUMBER _____ EMAIL _____ SOCIAL SECURITY # _____ MARITAL STATUS _____

DATE OF ACCIDENT _____ YOUR AUTO INSURANCE NAME _____ YOUR CLAIM NUMBER _____

ATTORNEY'S NAME _____ PHONE NUMBER _____

EMERGENCY CONTACT _____ RELATION _____ PHONE: _____

1. WERE YOU: DRIVER ___ PASSENGER ___ LOCATION: FRONT ___ BACK LEFT ___ BACK RIGHT ___ BACK MIDDLE ___
2. WERE YOU WEARING A SEATBELT? YES ___ NO ___ NUMBER OF PASSENGERS IN THE VEHICLE? _____
3. LOCATION OF ACCIDENT: _____
4. DESCRIBE THE ACCIDENT: _____
5. WAS THE POLICE NOTIFIED? YES ___ NO ___ DO YOU HAVE A POLICE REPORT? YES ___ NO ___
6. DID YOU GO TO THE HOSPITAL? YES ___ NO ___ WHICH HOSPITAL? _____
7. DID YOU HAVE ANY PHYSICAL COMPLAINTS PRIOR TO THE ACCIDENT? YES ___ NO ___
8. DESCRIBE: _____
9. DID YOU HAVE PAIN IMMEDIATELY AFTER THE ACCIDENT? YES ___ NO ___

   DID YOU HAVE PAIN LATER THAT DAY OR NEXT DAY? YES ___ NO ___ (IF YES, EXPLAIN): _____
10. CURRENT OCCUPATION _____ Full-Time ___ Part- Time ___
11. HAVE YOU LOST ANY TIME FROM WORK SINCE THE ACCIDENT? YES ___ NO ___ NUMBER OF DAYS LOST_____
12. DO YOU HAVE ANY PREVIOUS AUTO ACCIDENTS? YES ___ NO ___ IF SO, WHEN? _____
13. WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? _____
14. I WOULD LIKE TO RECEIVE EMAILS OF SPECIALS & PROMOTIONS? YES ___ NO ___ (opt-out)

I have been advised that I may have a deductible with my PIP insurance company. I may also be responsible for co-payments based on the Explanation of Benefits provided by the insurance company. I do not know how much the co-payments will be because my insurance company needs to supply my medical provider with an Explanation of Benefits first. Premier Total Healthcare has no agreement or intention to waive any deductible or co-payment. Florida Statute 817.234(7)(a) affords the medical provider protections in the event of a bodily injury settlement or verdict.

I have answered all the information truthfully and to the best of my knowledge. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and claims to assist me in collecting from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me by this office are ultimately my responsibility

FULL NAME _____

SIGNATURE _____ **DATE** _____

TYPE YOUR NAME IN THE SIGNATURE LINE

*If you are filling out this form online, typing your full name in the signature line indicates your agreement to the terms and conditions. If left blank, you may sign the form in person at Premier on the day of your appointment.

PREMIER
TOTAL HEALTHCARE

AUTO ACCIDENT DESCRIPTION

Patient Full Name _____ Date _____

Car Station Wagon Van Pickup Truck Large Truck Bus Other_____	Driver Front Passenger Left Rear Passenger Right Rear Passenger Other _____	Stopped at intersection Stopped in Traffic Stopped at light Making a right turn Making a left turn Parking Proceeding along Slowing down Accelerating Other _____

Time of accident _____ Your vehicle's speed: _____ mph Their vehicle's speed: _____ mph Damage to your vehicle Mild Moderate Totaled	Visibility at time of accident Poor Fair Good Who hit who/what You hit other vehicle Other vehicle hit you You hit...(object) _____	Road conditions at time of accident Icy Wet Sandy Dark Clean and dry Point of impact Head-On Left Front Right Front Rear-End Left Rear Right Rear

Did you see the accident coming: Yes No Were you braced for the impact? Yes No Did you have a seat belt on? Yes No Did you have a shoulder harness on? Yes No	Does your vehicle have headrests? Yes No What was the position of your headrest at the time of impact? Even with top of head Even with bottom of head Middle of neck What was the direction of your head at the time of impact? Facing straight forward Turned to the right Turned to the left
Did driver side airbags deploy? Yes No	Did passenger side airbags deploy? Yes No Did side airbags deploy? Yes No

Additional accident information

Enter any additional information below that is not covered by the above check offs.

Did your body strike the inside of the vehicle? Yes No If yes, describe: _____ Did you lose consciousness during the injury? Yes No If yes, for how long? _____ Your vehicle's estimated damage? _____ Damage to their vehicle: Mild Moderate Totaled Did police show up at the scene? Yes No Was an accident report filled out? Yes No	Check off your symptoms right after and a few days following: Headache Dizziness Mid back pain Cold hands Neck pain Nausea Low back pain Cold feet Neck stiffness Confusion Nervousness Diarrhea Fainting Fatigue Loss of taste Depression Ringing in ears Tension Toe numbness Anxious Loss of smell Irritability Constipation Chest pain Pain behind eyes Shortness of breath Sleeping problems Others: _____

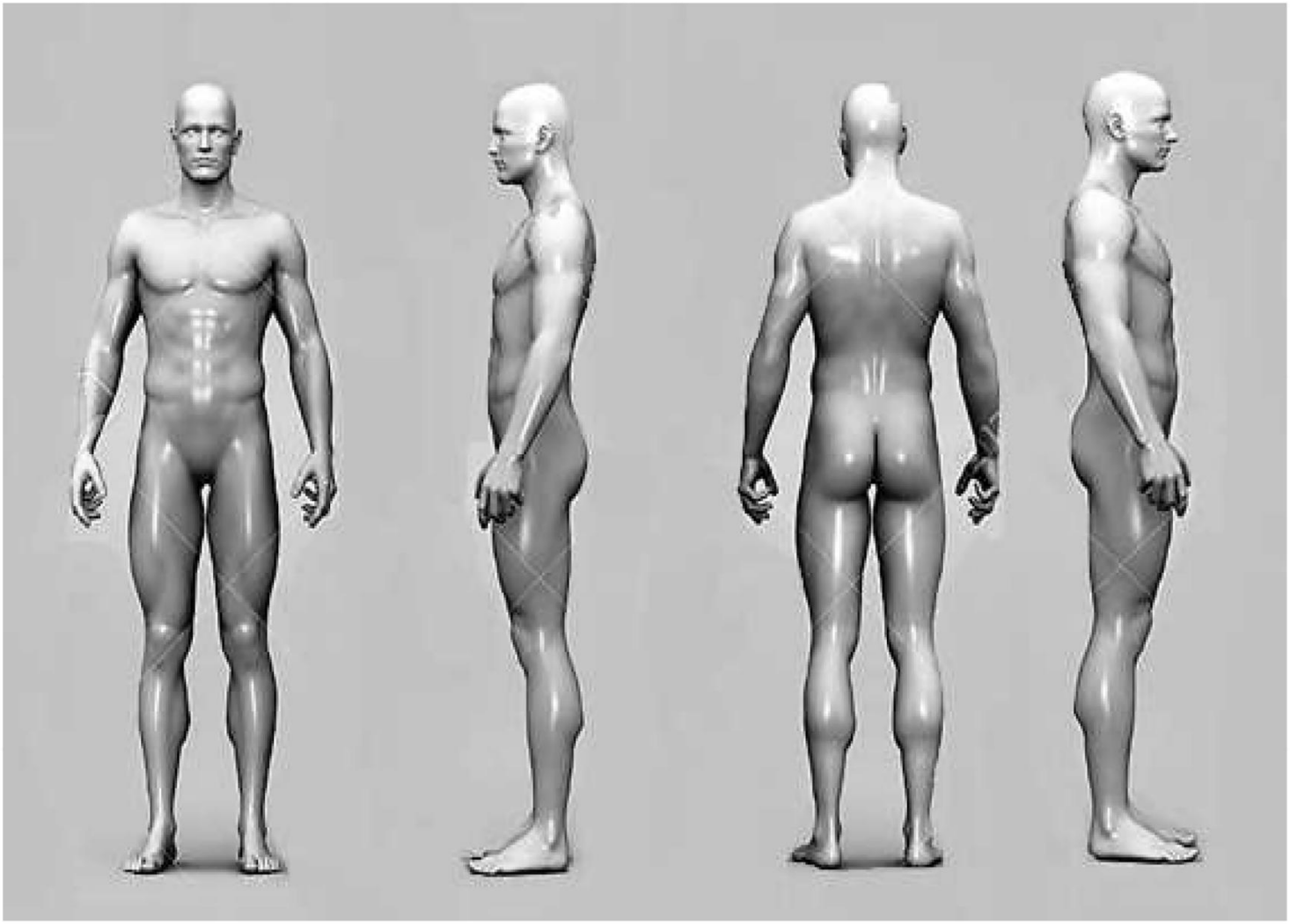
Where did you go after the accident? Home Work Hospital ER Private Doctor How did you get there? Drove self Somebody else Ambulance Police Where X-rays done? Yes No Was lab work done? Yes No Body parts X-rayed? _____ What lab work? _____ The X-rays revealed? _____ Treatments? Cervical Collar Ice Other: _____ Medications: _____ Follow-up instructions: _____	Fill in any other doctor(s) seen prior to your first visit to this office. 1. Dr. _____ First visit date: ____/____/____ Specialty: _____ X-rays done? Yes No Types of treatments received? _____ Did treatments benefit you? Yes No Last visit date: ____/____/____ 2. Dr. _____ First visit date: ____/____/____ Specialty: _____ X-rays done? Yes No Types of treatments received? _____ Did treatments benefit you? Yes No Last visit date: ____/____/____

Location of Pain

Mark your areas of concern with the corresponding symptoms where applicable

A= Achy/Dull B= Burning N= Numbness P= Pins & Needles S=Stabbing T= Tightness

*IF YOU ARE FILLING THIS FORM OUT ONLINE, LEAVE THE DIAGRAM BELOW BLANK UNTIL THE DAY OF YOUR APPOINTMENT



What is your pain level?

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Very Little Moderate Severe

Signature: _____ Date: _____

TYPE YOUR NAME IN THE SIGNATURE LINE
If you are filling out this form online, typing your full name in the signature line indicates your agreement to the terms and conditions. If left blank, you may sign the form in person at Premier on the day of your appointment.

MEDICAL HISTORY

Patient Full Name _____ Date _____

PLEASE SELECT ONLY THE ONES THAT APPLY BY CHECKING "YES" NEXT TO EACH CONDITION THAT APPLIES TO YOU

CARDIOVASCULAR		**NEUROLOGICAL**	
High Blood Pressure	☐ Yes	Stroke	☐ Yes
Heart Attack	☐ Yes	Seizures	☐ Yes
Angina / Chest Pain	☐ Yes	Fainting	☐ Yes
Heart Bypass Surgery	☐ Yes	Dizziness	☐ Yes
Stents	☐ Yes	Headaches/Migraines	☐ Yes
Pacemaker	☐ Yes	**CHRONIC PAIN**	
Defibrillator	☐ Yes	Sciatica	☐ Yes
Heart Failure	☐ Yes	Herniated Discs	☐ Yes
Irregular Heartbeat	☐ Yes	Neuropathy	☐ Yes
Heart Murmur	☐ Yes	Lower Back Pain	☐ Yes
ENDOCRINE		Neck Pain	☐ Yes
Hormone Imbalance	☐ Yes	Difficulty Moving Neck / Head	☐ Yes
Diabetes - Type 1	☐ Yes	Uses Cane / Walker to Ambulate	☐ Yes
Diabetes - Type 2	☐ Yes	**GASTROINTESTINAL**	
Hypothyroidism	☐ Yes	Gallstones	☐ Yes
Hyperthyroidism	☐ Yes	Liver Condition	☐ Yes
Hypoglycemia	☐ Yes	Kidney Condition	☐ Yes
High Cholesterol	☐ Yes	Ulcers	☐ Yes
RESPIRATORY		Hernias	☐ Yes
Asthma	☐ Yes	Heartburn	☐ Yes
Bronchitis	☐ Yes	Reflux	☐ Yes
Emphysema	☐ Yes	Irritable Bowel Syndrome	☐ Yes
COPD	☐ Yes	**SKIN**	
Shortness of Breath	☐ Yes	Skin Cancer - Where: _____	☐ Yes
Cough	☐ Yes	Radiation	☐ Yes
Cough with Sputum	☐ Yes	Scleroderma	☐ Yes
Sleep Apnea	☐ Yes	Psoriasis	☐ Yes
CPAP Machine at Night	☐ Yes	Eczema	☐ Yes
PSYCHIATRIC		**HEMATOLOGY**	
Depression	☐ Yes	Anemia	☐ Yes
Anxiety	☐ Yes	Clotting Disorder	☐ Yes
Psychiatric Care	☐ Yes	Sickle Cell	☐ Yes
Obsessive Compulsive Disorder	☐ Yes	Blood Clots	☐ Yes
Bipolar Disorder	☐ Yes	Bruises Easily	☐ Yes
Schizophrenia	☐ Yes	**OTHER**	
AUTOIMMUNE		Other Cancer - Where: _____	☐ Yes
Lupus	☐ Yes	Cold Sores	☐ Yes
Lyme Disease	☐ Yes	HIV / AIDS	☐ Yes
Multiple Sclerosis	☐ Yes	Hepatitis - Type: _____	☐ Yes
Vasculitis	☐ Yes	Hearing Loss	☐ Yes
Rheumatoid Arthritis	☐ Yes	Memory Loss	☐ Yes
Celiac Disease	☐ Yes		
Hashimoto's Disease	☐ Yes		

Please list any other medical conditions that are NOT listed above:

_____

_____

PREMIER
TOTAL HEALTHCARE

DISCLOSURE & CONSENT
FOR CHIROPRACTIC ADJUSTMENTS AND CARE

As a patient, you have the right to be informed about your condition and the recommended chiropractic adjustments and related procedures, so that you may make an informed decision regarding whether to proceed with treatment, with a full understanding of the potential risks and hazards involved.

I hereby voluntarily request and provide my informed consent to the performance of chiropractic adjustments and related procedures, including various modalities of physical therapy and diagnostic X-rays, for myself (or for the patient named below, for whom I am legally responsible). I understand that such services may be rendered by Dr. Kevin McGrath, DC and/or other duly licensed Doctor of Chiropractic, as well as qualified clinical personnel acting under their supervision, who are now or may in the future be employed by Premier Total Healthcare.

I acknowledge that I have been informed that, in the practice of chiropractic care, there are certain risks associated with examination and treatment, including but not limited to fractures, disc injuries, strokes, dislocations, sprains, increased symptoms or pain, or no improvement of symptoms or pain. I understand that it is not possible for the provider to anticipate and disclose every potential risk or complication, and I therefore rely on the provider to exercise professional judgment in determining the appropriate course of treatment based on the information available at the time and in my best interest. I further acknowledge that no guarantees or assurances have been made regarding the results or outcomes of the treatment.

SUD (Substance Use Disorder) Specially Protected Information (Initial Required)
I specifically authorize the release of the following **if applicable (initial each):**

☐ _____ Substance Use Disorder Treatment Records (including drug and alcohol abuse records)
☐ _____ Mental Health Records (excluding psychotherapy notes)
☐ _____ HIV/AIDS Test Results or Treatment
☐ _____ Genetic Test Results
This authorization expires when the following event occurs: When the patient provides notice of termination.

Substance use disorder records are protected by federal confidentiality rules (42 CFR Part 2).
Disclosure of these records is prohibited unless specifically authorized by the patient or otherwise permitted by law.
Any further disclosure of this information by the recipient may be prohibited.

I have read and understand the above consent and have initialed the SUD disclosure, where applicable. By signing below, I hereby consent to the proposed treatment plan and intend for this consent to apply to the entire course of treatment for my current condition, as well as any future condition(s) for which I may seek treatment.

Print Patient Full Name _____ Date _____

Patient Signature _____ Date _____
TYPE YOUR NAME IN THE SIGNATURE LINE
If you are filling out this form online, typing your full name in the signature line indicates your agreement to the terms and conditions. If left blank, you may sign the form in person at Premier on the day of your appointment.

To be completed by patient's representative if patient is a minor, physically or legally incapacitated

Print Full Name of Patient's Representative _____ Date _____

Representatives Signature _____ Date _____

Relationship to Patient _____

PREMIER
TOTAL HEALTHCARE

Declaration of Truth and Honorable Intent

1. **Consent for Examination and Procedures**
   I hereby give my consent to Dr. Kevin McGrath and authorize him to perform a physical examination and any routine diagnostic procedures as deemed necessary.
2. **Verification of Visit and Accident Relation**
   I hereby verify that my visit today is related or not related to an automobile accident, slip and fall, or work-related accident.
   If it is related, I have retained an attorney, not retained an attorney, or may retain an attorney at a later time.
   If I retain an attorney at any time during the course of my treatment, I agree to inform Premier Total Healthcare immediately. I will also disclose immediately if my attorney's representation changes.
3. **Authorization for Insurance Payment**
   With my signature below, I hereby authorize my insurance carrier to remit all payments directly to Premier Total Healthcare.

I hereby declare that all information provided to Premier Total Healthcare regarding my personal and medical history is complete, truthful, and accurate to the best of my knowledge. I affirm that I am not attempting to misrepresent, exaggerate, or magnify my condition for any reason. I confirm that I am seeking care voluntarily and of my own free will, and that I have not been directed or referred to by any individual or entity for any undisclosed purpose. Furthermore, I certify that I am not employed by, affiliated with, or acting on behalf of any government agency, corporation, or other organization for the purposes of deception, investigation, or entrapment.

I understand that my physician must rely on the accuracy and honesty of the information I provide in order to properly assess my condition and formulate an appropriate treatment plan.

_____ _____

Print Name Date Witness Print Date

_____ _____

Signature Date Witness Signature Date

TYPE YOUR NAME IN THE SIGNATURE LINE

If you are filling out this form online, typing your full name in the signature line indicates your agreement to the terms and conditions. If left blank, you may sign the form in person at Premier on the day of your appointment.

PREMIER
TOTAL HEALTHCARE

NOTICE OF DOCTOR'S LIEN

IMPORTANT: *This form is to be signed in-person during your appointment at Premier*

Patient: _____ Date of Accident: _____

I do hereby authorize Premier Total Healthcare Inc to furnish you, my attorney, with the full report from the physicians, physical therapist of their examination, diagnosis, treatment prognosis, etc of myself in regard to the accident I was recently involved.

I hereby authorize and direct you, my attorney or insurance company, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney or insurance company, or myself, as the result of the injuries for which I have been treated or injuries in connection to the accident.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor/clinic for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I also understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable by me, the patient.

_____ _____

Patient's Signature Date

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctor above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

_____ _____

Attorney's Signature Date

FILL THIS FORM OUT AT PREMIER DURING YOUR APPOINTMENT

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-1571
Pub. 1/2004

***FILL THIS FORM OUT AT PREMIER THE DAY OF YOUR APPOINTMENT**

PREMIER
TOTAL HEALTHCARE

2415 Hollywood Blvd, Hollywood, FL 33020 | Phone: 954-456-0250 | Fax: 954-456-0820 | Email: premier@mypthc.com

ASSIGNMENT OF INSURANCE BENEFITS, POWER OF ATTORNEY & RELEASE OF INFORMATION

I, the undersigned patient and/or insured, do hereby knowingly, voluntarily, and intentionally assign all rights, benefits, and proceeds of my automobile insurance policy, including but not limited to No-Fault Insurance (also known as Personal Injury Protection or "PIP") and Medical Payments coverage, to the medical provider **Premier Total Healthcare, INC** for services rendered in connection with injuries sustained in the relevant motor vehicle accident. This assignment includes all applicable benefits, overdue interest payments, and any potential claims for statutory or common law bad faith. It is the express intention of the provider to accept this Assignment of Benefits in lieu of requiring direct payment at the time services are rendered. If the insurer disputes the validity or enforceability of this Assignment, the insurer is hereby instructed to notify the provider in writing within five (5) days of receipt of this document.

The undersigned further directs the insurer to issue payment for services rendered directly to the provider, omitting the patient's name from the payment instrument. The insurer is expressly instructed not to issue any checks or drafts in partial settlement of a claim if such instruments contain, or are accompanied by, any language releasing the insurer or its insured from further liability, unless there is a prior written agreement between the provider and the insurer establishing the amount payable. The provider expressly objects to any unauthorized reductions or partial payments. Any such payments deposited by the provider shall be considered made under protest and shall not constitute an accord, satisfaction, waiver, discharge, settlement, or agreement to accept less than the full amount billed. The provider reserves the right to pursue the total outstanding balance.

Should any portion of the medical benefits be disputed, the undersigned instructs the insurer to place the disputed amount in escrow and refrain from disbursing those funds to any party, including the patient, until the matter is resolved. The insurer must provide written notice to the provider detailing the nature of any such dispute. In the event of a scheduled defense medical examination or examination under oath (EUO), the insurer is instructed to send a copy of the notice to the provider, who is authorized to attend. The provider is not an agent of either the insurer or the patient.

This Assignment shall remain in full force and effect unless revoked in writing by mutual agreement of both the undersigned (or the undersigned's legal representative) and the provider. It applies to both past and future services and is valid whether or not dated. A photocopy of this document shall be deemed as valid and enforceable as the original.

The undersigned acknowledges responsibility for any applicable deductible, co-payments, expenses incurred after policy limits are exhausted, and for any non-covered services unrelated to the automobile accident.

Power of Attorney: The undersigned grants the above-referenced provider; a limited power of attorney to endorse and deposit any checks made payable to the undersigned for services rendered by the provider.

Authorization for Release of Information: The undersigned authorizes the provider to:

- Furnish the insurer and the patient's attorney with all medical records related to treatment,
- Request and obtain insurance coverage information directly from the insurer,
- Request copies of all Explanation of Benefits (EOBs) and unredacted PIP payout logs from the insurer,
- Obtain copies of relevant medical records from other healthcare providers or insurers.

The insurer is instructed to maintain all medical records as confidential and is prohibited from disclosing them to any third-party, including vendors, without the express written authorization of both the patient and the provider.

The undersigned affirms that no promises, guarantees, or inducements have been made in exchange for receiving treatment, and that no assurances regarding treatment outcomes have been given.

IMPORTANT: Please read this document carefully before signing. If you have any questions or do not fully understand any part of this form, please ask for clarification. By signing below, you acknowledge that you have read, understood, and agree to the terms stated above.

Patient Name: _____ **Date**: _____

Patient Signature: _____
(If the patient is a minor, parent or legal guardian must sign.)

Demand Notice: A formal request is hereby made for the insurer to furnish a copy of the most recent PIP payout sheet and the complete insurance coverage declaration page to the provider within fifteen (15) days of receipt of this notice.

HIPAA Notice of Privacy Practices

PREMIER TOTAL HEALTHCARE
2415 HOLLYWOOD BLVD
HOLLYWOOD FL 33020
954.456.0250

Your Information. Your Rights. Our Responsibilities.

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 may 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 that relates to your past, present or future physical or mental health condition 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 our 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, 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, employee review, 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, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations, except SUD records as explained in Feb 15, 2026 addendum, 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, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Required Addendum to our NPP (Notice of Privacy Practices)

Effective as of February15,2026

PREMIER TOTAL HEALTHCARE
2415 HOLLYWOOD BLVD
HOLLYWOOD FL 33020
954-456-0250

Special Privacy Protections for Certain Health Information

We are **not primarily a substance use disorder (SUD) treatment program. We may receive and maintain SUD-related information incidentally** (e.g., referrals, history, meds, labs) and that information we maintain may be subject to additional federal privacy protections, including records related to the diagnosis, treatment, or referral for treatment of a substance use disorder. These records are protected by federal law (42 C.F.R. Part 2), which, in some cases, is more restrictive than HIPAA. When these stricter rules apply, we follow them.

How We May Use and Disclose Health Information

We may use and disclose your health information for treatment, payment, and health care operations. When information includes substance use disorder records, additional legal requirements may apply, including your written consent before using or disclosing that information.

Limits on Use of Substance Use Disorder Records

Federal law places **strict limits** on how substance use disorder records may be used or disclosed. Substance use disorder records cannot be used or disclosed to initiate or substantiate civil, criminal, administrative, or legislative proceedings without written consent or a qualifying court order.

Authorization and Consent

Certain uses and disclosures require written authorization. You may revoke authorization at any time by written request, except where already relied upon. If your health information includes substance use disorder records, your authorization may allow us to use and disclose that information for treatment, payment, and health care operations, as permitted by law.

Your Rights Regarding Your Health Information

You have rights to inspect, access, amend, request restrictions, request confidential communications, and receive an accounting of disclosures, as permitted by law.

Redisclosure Notice

If your health information is disclosed to another party, that party may be permitted to **redisclose** the information, and it may no longer be protected by HIPAA. However, **substance use disorder records** may continue to be protected by federal law even after disclosure, depending on the circumstances.

Public Health and De-Identified Information

We may disclose **de-identified health information** for public health, research, or health care operations purposes as permitted by law. De-identified information does not identify you and cannot reasonably be used to identify you.

Fundraising Communications

We may contact you for **fundraising purposes**. You have the right to **opt out** of receiving fundraising communications at any time. Your decision to opt out will **not affect your access to care**.

Complaints and Enforcement

If you believe your privacy rights have been violated, you may file a complaint with us or with the **U.S. Department of Health and Human Services**. You will not be retaliated against for filing a complaint.

Changes to This Notice

We reserve the right to change this Notice of Privacy Practices at any time. Any changes will apply to all health information we maintain. The current version of this Notice will be available upon request and on our website.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the 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

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

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 and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. 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. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication 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 have the right to request an amendment to 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 – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

You have the right to Choose someone to act for you: - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

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 Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

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. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Provided By HCSI

PT Signature **Date**

TYPE YOUR NAME IN THE SIGNATURE LINE

If you are filling out this form online, typing your full name in the signature line indicates your agreement to the terms and conditions. If left blank, you may sign the form in person at Premier on the day of your appointment.