Complete Women's Imaging, P.C.

GENERAL OUTPATIENT AUTHORIZATION

1. AUTHORIZATION FOR TREATMENT: I do hereby request and authorize Complete Women's Imaging, P.C. its staff to provide such care and administer such diagnostic and/or therapeutic procedures and treatment as, in the judgment of the physicians is deemed necessary or advisable in my (the patient's) care. I also consent to the photographing of any procedure to be performed, including the photographing of appropriate portions of my (the patient's) body, for the practice's internal purposes such as medical education and quality assurance. My consent is based upon the understanding that my (the patient's) identity will not be revealed to individuals outside of the Hospital by either pictures or other descriptive text accompanying the picture without obtaining further authorization from me.

2. ANCILLARY SERVICES: I further understand that certain practitioners may provide ancillary medical services to me (the patient) while I (the patient) am at Complete Women's Imaging, P.C. as imaging services (e.g., X-rays, MRI's) and pathology specimen examinations, and that these charges may not be included in the Complete Women's Imaging, P.C. charges. I understand that some of these practitioners may not provide services in my presence, but that they are actively involved in the course of my (the patient's) diagnosis and treatment. I hereby authorize payment directly to such practitioners under the policy(s) or plan(s) issued to me by my (the patient's) payor. I agree to pay all charges that become due with respect to such service to the extent the charge is due after credit is given for benefits paid on my (the patient's) behalf by payors.

3. AUTHORIZATION FOR RELEASE OF INFORMATION: By signing this document, I authorize Complete Women's Imaging, P.C. to release my (the patient's) personal health information: (a) to any requesting health care provider for my (the patient's) further diagnosis, care or treatment or for that provider's payment or health care operations purposes; (b) to any person or entity which may be responsible for billing and/or collection of claims for medical services or products provided by Complete Women's Imaging, P.C., its staff or practitioners under an insurance or other contract or obligation; (c) to any person or entity which is, or may be liable to Complete Women's Imaging, P.C. or me (the patient) for all or part of Complete Women's Imaging, P.C. charges or staff or physicians' charges, including, but not limited to, insurance companies, health maintenance organizations, workers' compensation carriers, or other third party payors (e.g., Medicaid, Medicare or Empire Blue Cross); (d) to any governmental agency or other organization responsible for oversight of Complete Women's Imaging, P.C.or third party payor; or (e) for Complete Women's Imaging, P.C. normal health care operations. I authorize the Hospital to allow the individuals listed above to access such information through any medium including over the Internet and through the Hospital electronic medical record system.

4. FINANCIAL AGREEMENT: I, the undersigned agrees, whether I sign as agent or as patient, that in consideration for the services rendered to me (the patient), I agree to pay all amounts, for which I am financially responsible, due for services presented in accordance with the rates and terms of Complete Women's Imaging, P.C.. I understand that to the extent permitted by law, where insurance or other third party benefits are insufficient to pay for all of my (the patient's) Complete Women's Imaging, P.C. and/or practitioner services rendered, that I will be responsible for the payment of any balances due as determined by the respective provider of services, including deductibles, copayments, coinsurance or other fees required by insurer, HMO or other benefit plan. I understand that if I have not provided Complete Women's Imaging, P.C. with accurate and current information regarding my insurer, HMO or other benefit plan/third party payor (e.g., Medicare or Medicaid) which provides me with health care coverage, I will be personally responsible for the case of all care rendered by Complete Women's Imaging, P.C. and its practitioners. I understand that the Complete Women's Imaging may require a consumer credit report in connection with the collection of an account. By signing this form I am providing Complete Women's Imaging with a written authorization to obtain a consumer credit report. I agree to pay all bills when presented.

5. AUTHORIZATION FOR PAYMENT: I hereby authorize payment to Complete Women's Imaging, P.C. and its related providers and entities all monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my hospital, medical care and treatment to cover the costs of care and treatment.

6. SIGNATURE ON FILE (FOR MEDICARE BENEFICIARIES): I certify that the information given to me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or Center for Medicare and Medicaid Services, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment or authorized benefits be made on my behalf to Complete Women's Imaging, P.C. and the Hospital and its related providers and entities which furnish services to me.

7. PERSONAL VALUABLES: I understand that Complete Women's Imaging, P.C. accepts no financial responsibility for the loss of any valuable and/or personal property I (the patient) choose(s) to retain during my visit. This includes, but is not limited to, jewelry, money, dentures, hearing aids, glasses, and clothes. I further release Complete Women's Imaging, P.C. from any responsibility for any article of value which may be taken from me (the patient) to properly carry out any test or procedure, or for any articles left at the practice which are not claimed within 60 days following my date of service.

8. JOINT NOTICE OF PRIVACY PRACTICES: I acknowledge receipt of the Patient Bill of Rights and HIPAA Joint Notice of Privacy Practice.

9. UNDERSTANDING OF THIS FORM: I confirm that I have read and fully understand this form. I have been given an opportunity to ask questions and all of my questions have been answered fully and to my satisfaction.

COMPLETE WOMEN'S IMAGING, PC

990 STEWART AVENUE, SUITE 100
GARDEN CITY, NY 11530

HIPAA JOINT PRIVACY NOTICE- This notice is effective as of March 19, 2013

THIS JOINT 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.

INTRODUCTION

This Joint Notice is being provided to you on behalf of Complete Women's Imaging, PC, with respect to services provided at 990 Stewart Ave Garden City, NY (collectively referred to herein as "We" or "Our"). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." "Protected health information" or "PHI" includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care. We will share protected health information with one another, as necessary, to carry out treatment, payment or health care operations relating to the services to be rendered at the Hospital facilities.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a written copy of our most current privacy notice from Ann Amato, Compliance and Privacy Officer at the Hospital or you can access it on our website at www.southnassau.org.

PERMITTED USES AND DISCLOSURES

We can use or disclose your PHI for purposes of *treatment, payment and health care operations*. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

- *Treatment* means the provision, coordination or management of your health care, including consultations between health care providers relating to your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the exercise regimen appropriate for your treatment.

- *Payment* means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and other utilization review activities. For example, we may need to provide PHI to your Third Party Payor to determine whether the proposed course of treatment will be covered or if necessary to obtain payment. Federal or state law may require us to obtain a written release from you prior to disclosing certain specially protected PHI for payment purposes, and we will ask you to sign a release when necessary under applicable law.

- *Health care operations* means the support functions of the Hospital, related to *treatment* and *payment*, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your PHI to evaluate the performance of our staff when caring for you. We may also combine PHI about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose PHI for review and learning purposes. In addition, we may remove information that identifies you so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may also use your PHI in the following ways:

- To provide appointment reminders for treatment or medical care.

- To tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

- To your family or friends or any other individual identified by you to the extent directly related to such person's involvement in your care or the payment for your care. We may use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.

- We may include certain limited PHI in the Practice directory. This may include your name, location, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. You may request not to be listed in the directory.

- When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.

- We will allow your family and friends to act on your behalf to pick-up filled prescriptions, medical supplies, X-rays, and similar forms of PHI, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

- We may contact you as part of our fundraising and marketing efforts as permitted by applicable law. You have the right to opt out of receiving such fundraising communications.

- We may use or disclose your PHI for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.

- We will use or disclose PHI about you when required to do so by applicable law.

- In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or the Hospital as required by applicable law.

Note: incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

SPECIAL SITUATIONS-HOSPITAL LOCATIONS OR OTHERWISE

Subject to the requirements of applicable law, we will make the following uses and disclosures of your PHI:

- Organ and Tissue Donation. If you are an organ donor, we may release PHI to organizations that handle organ procurement or transplantation as necessary to facilitate organ or tissue donation and transplantation.

- Military and Veterans. If you are a member of the Armed Forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

- Worker's Compensation. We may release PHI about you for programs that provide benefits for work-related injuries or illnesses.

- Public Health Activities. We may disclose PHI about you for public health activities, including disclosures:

  * to prevent or control disease, injury or disability;
  * to report births and deaths;
  * to report child abuse or neglect;
  * to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;
  * to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  * to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.

- Health Oversight Activities. We may disclose PHI to federal or state agencies that oversee our activities (e.g., providing health care, seeking payment, and civil rights).

- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI subject to certain limitations.

- Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

  * In response to a court order, warrant, summons or similar process;
  * To identify or locate a suspect, fugitive, material witness, or missing person;
  * About the victim of a crime under certain limited circumstances;
  * About a death we believe may be the result of criminal conduct;
  * About criminal conduct on our premises; or
  * In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.

- Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner. We may also release PHI about patients to funeral directors as necessary to carry out their duties.

- National Security and Intelligence Activities. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, other national security activities authorized by law or to authorized federal officials so they may provide protection to the President or foreign heads of state.

- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

***Note*: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable state and federal law. Any disclosures of these types of records will be subject to these special protections.**

OTHER USES OF YOUR HEALTH INFORMATION

Certain uses and disclosures of PHI will be made only with your written authorization, including uses and/or disclosures: (a) of psychotherapy notes (where appropriate); (b) for marketing purposes; and (c) that constitute a sale of PHI under the Privacy Rule. Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of PHI for treatment, payment and health care operations. However, we are not required to agree to your request unless the disclosure is to a health plan in order to receive payment, the PHI pertains solely to your health care items or services for which you have paid the bill in full, and the disclosure is not otherwise required by law. To request a restriction, you must make your request in writing to the Director of Health Information Management (HIM).

2. You have the right to reasonably request to receive confidential communications of your PHI by alternative means or at alternative locations. To make such a request, you must submit your request in writing to the Director of Health Information Management (HIM).

3. You have the right to inspect and copy the PHI contained in our Hospital records, except:

(i) for psychotherapy notes, (i.e., notes that have been recorded by a mental health professional documenting counseling sessions and have been separated from the rest of your medical record);
(ii) for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
(iii) for PHI involving laboratory tests when your access is restricted by law;
(iv) if you are a prison inmate, and access would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, any officer, employee, or other person at the correctional institution or person responsible for transporting you;
(v) if we obtained or created PHI as part of a research study, your access to the PHI may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;
(vi) for PHI contained in records kept by a federal agency or contractor when your access is restricted by law; and
(vii) for PHI obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

In order to inspect or obtain a copy your PHI, you must submit your request in writing to the Office Manager. If you request a copy, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

We may also deny a request for access to PHI under certain circumstances if there is a potential for harm to yourself or others. If we deny a request for access for this purpose, you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request an amendment to your PHI but we may deny your request for amendment, if we determine that the PHI or record that is the subject of the request:

(i) was not created by us, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
(ii) is not part of your medical or billing records or other records used to make decisions about you;
(iii) is not available for inspection as set forth above; or
(iv) is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your PHI, you must submit your request in writing to the Director of Health Information Management (HIM) at our Hospital, along with a description of the reason for your request.

5. You have the right to receive an accounting of disclosures of PHI made by us to individuals or entities other than to you for the six years prior to your request, except for disclosures:

(i) to carry out treatment, payment and health care operations as provided above;
(ii) incidental to a use or disclosure otherwise permitted or required by applicable law;
(iii) pursuant to your written authorization;
(iv) for the Hospital's directory or to persons involved in your care or for other notification purposes as provided by law;
(v) for national security or intelligence purposes as provided by law;
(vi) to correctional institutions or law enforcement officials as provided by law;
(vii) as part of a limited data set as provided by law.

To request an accounting of disclosures of your PHI, you must submit your request in writing to the Director of Health Information Management (HIM) at our Hospital. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred. Contact Person for Health Information Management (HIM):

Suzanne Farca, COO
Complete Women's Imaging, PC
990 Stewart Ave
Garden City, NY 11530
Fax Number: (516) 222-4885

6. You have the right to receive a notification, in the event that there is a breach of your unsecured PHI, which requires notification under the Privacy Rule.

COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact:

Suzanne Farca, COO
Complete Women's Imaging, PC
990 Stewart Ave
Garden City, NY 11530
Fax Number: (516) 222-4885

We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of the U. S. Department of Health and Human Services.

CONTACT PERSON

If you have any questions or would like further information about this notice, please contact **Suzanne Farca, COO 516-222-4863**