Canton Family Health
HIPAA Authorization

Patient Name: _____ Patient DOB: _____

I understand that I have certain rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Protected health information can include, but is not limited to, identifying factors such as name, address, and social security number, and, any information relating to diagnosis, treatment, services provided, and claims.

By signing this form, I authorize Canton Family Health, its affiliates, employees, and agents, to use and disclose protected health information when necessary and appropriate for my care. This includes sharing information for services/treatment, payment, and healthcare operations. I have also been advised of this practice's Privacy Practices.

I understand that any personal health information or other information released to Canton Family Health may be subject to re-disclosure by this organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to Canton Family Health. However, any use or disclosure of information prior to the date that I revoke this consent is not affected.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. If I refuse to sign, Canton Family Health has the right to deny me services and treatment, determined at the practice's discretion.

I understand that I may request a copy of this authorization. I understand that Canton Family Health reserves the right to change this policy from time to time, and I may request a copy of the most current policy at any time.

May we discuss your medical condition(s) with any member of your family? YES NO

If YES, please name the member(s) allowed: _____

_____

Patient Printed Name Date/Time

_____

Signature of Patient, Legal Representative, or Guardian Relationship to Patient

Canton Family Health
Patient Financial Responsibility Agreement

Please review our financial policies below:

1. Canton Family Health (CFH) and its providers participate in Medicare and other commercial insurances. It is your responsibility to know if your plan is accepted by our providers and your plan's specific coverage. If your insurance does not fully cover or denies payment for your service, you will be responsible for the remaining charge. **Any applicable co-payments are due at the time of service.** Failure to make this co-payment at the time of service may result in your appointment being rescheduled.

2. When an account balance becomes your responsibility, the balance is due upon receipt of the first account statement from CFH. If any part of the balance becomes delinquent, then the account balance may be forwarded to an outside agency for collection. A $30 returned check fee will be applied for non-sufficient funds.

3. If you make an appointment for a physical/wellness visit and your doctor treats you for an illness or counsels you regarding a medical condition during that visit, you may be responsible for a separate co-payment.

4. For patients who do not have insurance or have insurance that is not contracted with CFH, a minimum $75 deposit is required at time of service. If the entire balance is not paid in full at time of service, this will be billed to you.

5. While we understand that certain obligations or unforeseen emergencies may arise, we ask that you provide the clinic at least a 24-hour notice for cancelling an appointment. If this notice is not provided in the 24-hour timeframe, a $50 no-show fee will be applied to your account. This fee will be applied to any and each appointment missed without reasonable cause and without 24-hour notice prior. If your appointment is on a Monday, you may notify our practice through phone, voicemail, or patient portal message. If you no-show multiple appointments or cancel multiple consecutive appointments, you may be discharged from the practice, at your physician's discretion. In this case, the provider will notify you by writing that you have been discharged.

I have read and understand the above Financial Responsibility policy and agree to the terms detailed above.

Patient Printed Name Date/Time

Signature of Patient, Legal Representative, or Guardian Relationship to Patient

Canton Family Health
General Consent to Treat

I consent to treatment by Canton Family Health, its physicians and ancillary staff, as deemed necessary and advisable. This treatment includes, but is not limited to, diagnostic examinations, procedures, and treatments, including medications administered under the instructions of the physicians. I understand that my care is directed by my physicians, and that other personnel render care and services under the instructions of the physicians. I understand that medicine is not an exact science and the practitioners can make no assurances as to results or outcomes.

By signing this form, I authorize Canton Family Health, Dr. Samih Ajami, Dr. Shadia Yeihey, and staff to treat me (my child) and use my (my child's) personal health information for continuity of health care purposes.

Patient Printed Name	Date/Time
Signature of Patient, Legal Representative, or Guardian	Relationship to Patient

Canton Family Health
Notice of Privacy Practices

This notice describes how your protected health information may be used and disclosed. Please review it carefully.

Personally identifiable information about your health, your health care, and your payment for health care is called Protected Health Information (PHI). This notice explains how, when, and why we may use or disclose your PHI. Except in the situations described in this notice, we must use or disclose only the minimum necessary PHI to carry out the use or disclosure.

You may request a copy of this notice at any time.

Uses and Disclosures of Your Protected Health Information That Do Not Require Your Consent

For treatment purposes. We may disclose your PHI to doctors, nurses, and others who provide health care to you.

To obtain payment. We may disclose your PHI in order to collect payment for your health care, such as from your insurance company.

For health care operations. We may use or disclose your PHI in order to perform business functions, such as employee evaluations or improving the service we provide. We may disclose your information to students or residents training with us. We may use your information to contact you to remind you of your appointment or to call you by name in the waiting room.

When required by law. We may be required to disclose your PHI to law enforcements officers, courts, or government agencies. For example, we may have to report abuse, neglect, or certain physical injuries.

For public health activities. We may be required to report your PHI to government agencies to prevent or control disease or injury. We also may have to report work-related illnesses and injuries to your employer so that your workplace may be monitored for safety.

For health oversight activities. We may be required to disclose your PHI to government agencies so that they can monitor or license health care providers such as doctors or nurses.

For activities related to death. We may be required to disclose your PHI to coroners, medical examiners, and funeral directors so that they can carry out duties related to your death, such as determining the cause of death or preparing your body for burial. We may also disclose your information to those involved with locating, storing, or transplanting donor organs or tissue.

To avert a threat to health or safety. In order to avoid a serious threat to health or safety, we may disclose your PHI to law enforcement officers or other persons who might prevent or lessen that threat.

For specific government functions. We may disclose PHI of military officers or veterans in certain situations to correctional facilities, to government benefit programs, and for national security reasons.

For workers' compensation purposes. We may disclose your PHI to government authorities under workers' compensation laws.

For fundraising purposes. We may use certain information (such as demographics, dates of services, department of service, treating physicians, and outcomes) to send fundraising communications to you. However, you may opt out of receiving such communications to you by contacting our clinic. Your decision to opt-out will have no impact on your treatment.

Uses and Disclosures of Your Protected Health Information That Offer You an Opportunity to Object

In the following situations, we may disclose some of your PHI if we first inform you about the disclosure and you do not object:

In patient directories. Your name, location, and general health condition may be listed in our patient directory for disclosure to callers or visitors who ask for you by name. Additionally, your religion may be shared with clergy.

To your family, friends, or others involved in your care. We may share with these people information related to their involvement in your care or information to notify them as to your location or general condition. We may release your health information to organizations handling disaster relief efforts.

Uses and Disclosures of Your Protected Health Information That Require Your Consent

The following uses and disclosures of your PHI will be made only with your written permission, which you may withdraw at any time:

For research purposes. In order to serve our patient community, we may want to use your health information in research studies. For example, researchers may want to see whether your treatment cured your illness. In such an instance, we will ask you to complete a form allowing us to use or disclose your information for research purposes. Completion of this form is completely voluntary and will have no effect on your treatment.

For marketing purposes. Without your permission, we will not send you mail or call you on the telephone in order to urge you to use a particular product or service, unless such a mailing or call is part of your treatment. Additionally, without your permission, we will not sell or otherwise disclose your PHI to any person or company seeking to market its products or services to you.

Of psychotherapy notes. Without your permission, we will not use or disclose notes in which your doctor describes or analyzes a counseling session in which you participated, unless the use

or disclosure is for on-site student training, for disclosure required by a court order, or for the sole use of the doctor who took notes.

For any other purposes not described in this Notice. Without your permission, we will not use or disclose your health information under any circumstances that are not described in this Notice.

Your Rights Regarding Your Protected Health Information

You have the following rights related to your PHI:

To inspect and request a copy of your Protected Health Information. You may look at and obtain a copy of your PHI in most cases. You may not view or copy psychotherapy notes, information collected for use in a legal or government action, and information which you cannot access by law. If we use or maintain the requested information electronically, you may request that information in electronic format.

To request that we correct your Protected Health Information. If you think that there is a mistake or a gap in our file of your health information, you may ask us in writing to correct the file. We may deny your request if we find that the file is correct and complete, not created by use, or not allowed to be disclosed. If we deny your request, we will explain our reasons for the denial and your rights to have the request, denial, and your written response added to your file. If we approve your request, we will change the file, report that change to you, and tell others that need to know about the change in your file.

To request a restriction on the use or disclosure of your Protected Health Information. You may ask us to limit how we use or disclose your information, but we generally do not have to agree to your request. An exception is that we must agree to a request not to send PHI to a health plan for purposes of payment or health care operations if you have paid in full for the related product or service. If we agree to all or part of your request, we will put our agreement in writing and obey it except in emergency situations. We cannot limit uses or disclosures that are required by law.

To request confidential communication methods. You may ask that we contact you at a certain address or in a certain way. We must agree to your request as long as it is reasonably easy for us to do so.

To find out what disclosures have been made. You may get a list describing when, to whom, why, and what of your PHI has been disclosed in the past 2 years. We must respond to your request within 60 days of receiving it. We will only charge you for the list if you request more than one list per year. The list will not include disclosures made to you or for purposes of treatment, payments, health care operations if we do not use electronic health records, our patient directory, national security, law enforcement, and certain health oversight activities.

To receive notice if your records have been breached. Canton Family Health will notify you if there has been an acquisition, access, use or disclosure of your PHI in a manner not allowed

under the law and which we are required by law to report to you. We will review any suspected breach to determine the appropriate response under the circumstances.

To obtain a paper copy of this Notice. Upon your request, we will provide you with a paper copy of this Notice.

How to Complain about Our Privacy Practices

If you think we may have violated your privacy rights, or if you disagree with a decision we made about your Privacy Practice, you can mail a complaint to our office, Canton Family Health, 6300 N Haggerty Rd, Suite 220, Canton, MI, 48187.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services by writing to 200 Independence Avenue, S.W., Washington, D.C., 20201 or by calling 1-877-696-6775.

We will take no action against you if you make a complaint to either or both of these persons.

How to Receive More Information about our Privacy Practices

If you have any questions about this Notice or about our privacy practices, please contact our office at 1-734-365-6804.

Effective Date

This Notice is effective as of April 1, 2022.