Tiger City Wellness, LLC HIPAA Notice Privacy Practices

"PHI" or Protected Health Information" includes name, birthdate, contact information. It also includes information about our health, medical conditions, treatments and prescriptions that may be obtained. This information is obtained by our providers during your visit. Billing, payment and information regard insurance is included in PHI. Below explains how your information may be used and explains your rights regarding this information. As required by law, Tiger City Wellness, LLC must abide by the terms to ensure your information is kept private. This is serves as notice of our legal duties and practices regarding your PHI. In the event of breach, you will be notified.

Uses and disclosures of Your PHI for Treatment, Payment, and Healthcare Operations
In order to provide **treatment**, we may use your PHI. This may include providing info to 3rd parties such as pharmacies, doctors, hospitals, or other health care providers. PHI may be used to obtain reimbursement for services or **payment**. You may be contacted directly as well as your insurance company regarding balances. For TCW, LLC to continue to provide quality services we may use your PHI to monitor trends, quality of services, coordinate care and evaluate staff to improve our **operations**.

PHI may also be shared without you consent to Business associates(billing and consulting), individuals involved in you care(friend, family or personal representative, etc), parents or legal guardians when permitted or required under state law, when required by law, workers compensation, law enforcement (injuries, when information constitutes evidence of criminal conduct, subpoena, court order, warrant), judicial and administrative proceedings, public health reporting required by law, reporting abuse or neglect, health oversight activities, research, decedents, organ and tissue donation, correctional institutions, to avert serious threats to health and safety, specialized government functions and affiliated covered entities.

Consent is required for one purposes of disclosing PHI including marketing and to sell PHI to 3rd parties. In these instances, it is required by law that we obtain written consent. Consent make be revoked at anytime by submitting written notice to TCW, LLC IF you have questions, please contact Tiger City Wellness, LLC.

Your Heath Information Rights
You have the right to see and review PHI obtained about you. This can be done by submitting a written request. You can also provide a copy to other providers or entity at your request. A reasonable fee maybe charges for the expense of fulfilling such request as permitted under HIPAA and/or state law. Amendments of PHI may be requested in writing if you feel PHI is incorrect. You have the right to request restrictions or certain use and disclosure of you PHI. You have the right to request that we communicate with you in a certain way or location. These requests can be made in writing. We will notify if there is any breach of your PHI. You may exercise your right through a personal representative as applicable by law. The is no penalty for filing a complain if you feel your privacy rights have been violated. Complaints must be submitted in writing to TCW, LLC. Visit www.tigercitywellness.com or email fnp@tigercitywellness.com for current address.

Changes to this Notice
We reserve the right to make changes to this notice as permitted by law and to make revised Notice effective for PHI we already have about you and well as any information obtain in the future.

Effective Date: This notice is effective as of March 18, 2020.

Last updated March 18, 2020

Notice of Privacy Practices

☐ I acknowledge that I have received the Tiger City Wellness, LLC Notice if Privacy Practices. ____initials

Acknowledgement and General Consent to Examine

Tiger City Wellness, LLC Services

I hereby authorize physical examination at Tiger City Wellness, LLC.

Sports, camp, college school daycare and DOT physicals.

You have the right to discuss with your practitioner any cultural, religious, spiritual or other preferences that impact you visit. If you have language or communication challenges, please notify provider.

Patient Financial Responsibility
You are responsible for paying for services at the time they are provided. Tiger City Wellness, LLC currently does not have any agreement or contract with any health plan.

By signing below, I am confirming that I understand the above disclosures and consent to the physical examination, that I will receive and/or that will be received by the minor named below for whom I attest that I am the parent, legal guardian or authorized representative of and that may provided effective consent for this service.

____ ______________________
Patient Name (Please Print) Date

____ ______________________________
Signature Parent/Guardian/Authorized representative
*If signed by anyone other than the patient, please describe relationship to the patient

Patient Name: ______________________ Today's Date: ______________________________
Address: ____ DOB: ___________________________

Part One: TO BE COMPLETED BY PATIENT

Reason for exam: ____

Current Medications:(including over the counter and herbal supplements):

Name	Dose	Frequency?	Reason for Medication?

Allergies? Yes/No If yes list:____
Immunizations: **(date/NA)** Flu: ________ Tdap:_________ Pneumonia:_________ Shingles:_________

Review of Systems: If history of items listed below, mark YES. Elaborate on yes in comments sections

System	YES	NO	System	YES	NO	System	YES	NO
GENERAL			**Genitourinary**			**PSYCHIATRIC**		
Weight loss			Painful urination			Anxiety		
Fatigue			Blood in urine			Depression		
Memory Loss			Irregular period					
HEENT			**GASTROINTESTIONAL**					
Headache			Nausea			**DIAGNOSES**		
Vision Loss			Vomiting			Diabetes		
Hearing Trouble			Diarrhea			Hypertension		
Sinus Pain			Abdominal Pain			GERD		
CARDIOVASCULAR			**MUSCULOSKELETAL**			COPD		
Chest Pain			Joint Pain			GOUT		
Irregular Heartbeat			Join Swelling			High Cholesterol		
Elevated BP			Limited Movement			Asthma		
Swelling			**NEUROLOGICAL**			Allergies		
RESPIRATORY			Dizziness			UTI		
Cough			Seizure					
Wheeze			Fainting/Blackouts					
Shortness of Breath			Numbness/Tingling					

COMMENTS:
____
____
____

Patient Signature:____ Date: _________________________

Part Two: TO BE COMPLETED BY PROVIDER

PHYSICAL EXAM

Patient Name: _______________________________________ DOB: __________________

Vital Signs:

Height______ Weight_____ Blood Pressure_____ Pulse_____ Resp______ Temp______ Vision_____

TB(tuberculosis) Screening
Is TB testing require for this exam? Yes ☐ No☐

If yes: Date given: _____________ Date read: ____________ Results: ___________

System Exam	(YES) Normal (NO)		Comments/Abnormal Findings
Eyed			
Ears			
Nose			
Mouth/Throat			
Head/Face/Neck			
Lungs			
Cardiovascular			
Extremities			
Abdomen/GI			
Musculoskeletal			
Skin			
Genitourinary (male)*			
Lymphatic			
Endocrine			
Neurological			

*Consider/complete exam if hernia suspected or if required by. Chaperone recommended

Comments:____
____
____
____

Name of Provider(print):____ Date:________________

Provider Signature:____ Patient Signature:__________________

Clinic Address:____ Phone Number:___________________

Last updated March 18, 2020

TIGER CITY WELLNESS, LLC