Dear New Patient,

Please allow us to introduce ourselves. Welcome to Midwest Medical Practitioners and thank you for choosing us as your Primary Care Provider (PCP). We are pleased to serve as your physicians and look forward to partnering with you in your care. Continuity and coordination of patient care is vital to meeting your healthcare needs. Our physicians, nurse practitioners, medical assistants, and office staff work in partnership to support your patient care.

Our office is open **Monday through Friday from 9 A.M. to 5 P.M**. Please note that our schedulers are available during office hours and will do their best to accommodate you. Scheduling an appointment is imperative to ensuring all patients receive the time they require for quality medical care.

Before you visit, please notify your health insurance company of your new primary care doctor if necessary. We also ask you to please notify your previous physician and specialists to request a copy of your medical records to be faxed to our office.

- New Patient Packet
- **Medical Insurance Cards will be required at the time of check in EVERY VISIT**
- Photo ID will be required at the time of check in.

A complete list of all medications, vitamins, minerals, supplements, and herbs including the strength, dosage, and how many times a day you take it.

Please be prepared to pay for a copay if one is listed. Our office accepts cash, check and credit/debit cards.

Our office as a whole does not prescribe routine controlled medications. If you are on controlled medications we are more than willing to send referrals to specialists to handle those prescriptions.

Sincerely, The Providers and Staff of Midwest Medical Practitioners

New Patient Registration Form

Personal Information

Last Name	First Name	MI	Preferred Name

Male		Street		State	
Female		City		Zip	

Date of Birth		Social Security No.	
Race/Ethnicity		Preferred Language	
Home Phone		Mobile Phone	
Work Phone		Preferred Method Of Contact?	
Employer		Phone	
Email			

Would you like to receive correspondence and appointment reminders via email? **Yes** or **No**

Single		Married		Separated		Divorced		No. Of Children	

Emergency Contact

Name:	**Relationship:**
Address:	**Phone:**

Insurance Information

Primary Insurance	Insurance ID & Group No.	Effective Date
Secondary Insurance	Insurance ID & Group No.	Effective Date

Insured or Responsible Party

Relationship to patient:		
Last Name:	First Name:	Date of Birth:
Address:		
Social Security No.:	Phone:	

Signature:_____ **Date:**_____

CONSENT TO TREAT, ASSIGNMENT AND RELEASE

I do hereby consent to and authorize the performance of all treatments and medical services deemed advisable by the physicians and staff of Midwest Medical Practitioners for me. I hereby certify that, to the best of my knowledge, all statements contained herein are true. I hereby authorize my insurance/Medicare benefits be paid directly to Midwest Medical Practitioners and I am financially responsible for non-covered services. I also authorize Midwest Medical Practitioners to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees. I fully understand this agreement and consent will continue until canceled by me in writing

_____

Print Patient Name

_____

Patient Signature Date

Patient Name:_____ Date of Birth:_____

Patient Medical History

Allergies

☐ No known Allergies	☐ Penicillin	☐ Dairy Products	☐ Latex
☐ Sulfa Drugs	☐ Shellfish	☐ Adhesive Tape	☐ Aspirin
☐ Peanuts	☐ Iodine	☐ Morphine	☐ Eggs
☐ Contrast Dye	☐ Codeine	☐ Wheat	☐ Anesthesia
☐ Lidocaine	☐ Other _____		

Family History

Mother	Father	Siblings	
☐	☐	☐	Coronary Disease
☐	☐	☐	High Blood Pressure
☐	☐	☐	Diabetes
☐	☐	☐	Obesity
☐	☐	☐	Stroke
☐	☐	☐	Thyroid Disorder
☐	☐	☐	Arthritis
☐	☐	☐	Alcoholism
☐	☐	☐	Cancer

Social History

Do you use tobacco products? If so, for how long? Yes ☐ or No ☐ How Long:_____

How often do you drink alcohol?

☐ Never ☐ Seldom ☐ Daily ☐ Weekly

☐ Recovering Alcoholic ☐ Only Socially

Have you had a LDCT? If yes, when?

☐ Yes ☐ No When:_____

How many people live with you?

Children:_____ Adults:_____

Have you EVER had any of the following conditions:

☐ AIDS/HIV Positive	☐ Alcohol Dependency	☐ Anaphylaxis	☐ Anemia
☐ Asthma	☐ Arthritis/Gout	☐ Atrial Fibrillation	☐ Artificial Heart Valve
☐ Artificial Joint	☐ Blood Transfusion	☐ Bleeding Problems	☐ Breathing Problems
☐ Coronary Artery Disease	☐ Congestive Heart Failure	☐ Depression	☐ Diabetes
☐ Drug Abuse	☐ Erectile Dysfunction	☐ Epilepsy/Seizures	☐ Fibromyalgia
☐ Fainting/Dizziness	☐ Genital Herpes	☐ Heart Disease/Murmur	☐ Hepatitis A
☐ Hepatitis B or C	☐ High Blood Pressure	☐ High Cholesterol	☐ Hypoglycemia
☐ Kidney Problems	☐ Leukemia	☐ Liver Disease	☐ Low Blood Pressure
☐ Memory Issues	☐ Osteoporosis	☐ Radiation Treatments	☐ Renal Dialysis
☐ Rheumatic Fever	☐ Shingles	☐ Stroke	☐ Swelling of Limbs
☐ Thyroid Disease	☐ Tuberculosis	☐ Tumors/Growths	☐ Stomach Ulcers
☐ Venereal Disease	☐ Irregular Heartbeat	☐ Other:_____	

Patient Name:_____ Date of Birth:_____

Patient Medical History

Who was your last Primary Care Physician (PCP)?

Name:_____ Address:_____

Phone:_____ Fax:_____

Do you see any Specialist providers (Cardiologist, Oncologist, ect.)

Name:_____ Address:_____

Phone:_____ Fax:_____

Name:_____ Address:_____

Phone:_____ Fax:_____

What was the date of your last:

Mammogram:_____

Colon Cancer Screening:_____

DEXA Scan:_____

Cervical Exam:_____

Have you ever been diagnosed with: ☐ Type 1 Diabetes ☐ Type 2 Diabetes

Last A1c and date it was taken:_____

Date of last KED (Kidney Health Evaluation, Urine Microalbumin, eGFR) and who performed it:

_____

Last Diabetic Eye Exam (Retinavue):_____

Do you utilize any medical equipment (Walker, Wheelchair, CPAP, Cane, Rollator, Etc.)

_____

_____

Do you use Oxygen? ☐ Yes ☐ No

If yes, what type of equipment? (Concentrator, Tank, BiPAP, CPAP):_____

How many Liters Per Minute (LPM)?_____

What company do you get your supplies from (Lincare, American Home Patient, Medical West, Ect)?

_____

Patient Name:_____ Date:_____

Please list all surgeries/procedures, the performing physician and the dates performed:

Surgery/Procedure	Performing Physician	Date Performed

Please list all medications you are currently taking, including dosage and frequency:

Date Started	Medication	Dose/ MG	Frequency (Times per day)	Time its taken

---

Preferred Pharmacy

Name:_____ Address:_____

Phone:_____ Fax:_____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

This document authorizes the release of health information records for the patient listed below:

PATIENT: ..... (LAST / FIRST / MIDDLE / MAIDEN)

ADDRESS: ..... (STREET / CITY / STATE / ZIP)

SSN: DOB: PHONE:

I understand that my records may contain sensitive information regarding the diagnosis or treatment of HIV (AIDS Virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I hereby release any one, or all of you collectively, from any illegal responsibility that may arise from the above act authorized by me.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

....
Signature of Patient/Parent/Guardian or Authorized Representative — Date

....
Signature of Witness — Date

The information below is for office use. Please DO NOT fill out the rest of this page.

I HEREBY AUTHORIZE: (the entity who has your records)

NAME/BUSINESS:..... PHONE:.....

ADDRESS: ..... FAX:.....

To release all information checked below:

☐ Physician's Office Notes	☐ Cardiology/EKG Reports	☐ History
☐ Lab/Pathology Reports	☐ Operative/Procedure Reports	☐ Rehab
☐ Radiology/XRays/MRI Reports	☐ Medical Records to further Health	☐ Physicals
☐ Immunizations	☐ Medical Financial Reports	☐ Consultations

SEND THE INDICATED INFORMATION TO: (the party receiving your health information)

NAME/BUSINESS:..... PHONE:.....

ADDRESS:..... FAX:.....

PATIENT CONSENT TO AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTION

The purpose of this contract is to protect your (the patient's) access to controlled substances and to protect Midwest Medical Practitioners, LLC's (hereafter referred to as MMP) ability to prescribe to you.

Patients who are prescribed controlled drugs are at risk of developing an addictive disorder or suffering a relapse of a prior addiction. The extent of this risk is not certain.

Because these drugs can be abused by the patients who receive them, or by others, it is necessary to observe the strict rules when they are prescribed over the long term. For this reason, we require each patient receiving long-term treatment with these medications to read and adhere to the following agreement.

You, the patient, agree to follow the terms and procedures described in this agreement as consideration for, and as a condition of, the willingness of the physician/nurse practitioner, whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat your condition.

1. All my controlled substances must be prescribed by a physician/nurse practitioner from this practice. My controlled substances will come from the physician/ nurse practitioner whose signature appears below, or during his/her absence, by the covering prescriber.

I will inform my physician/nurse practitioner of any current or past substance abuse, or any current or past substance abuse of an immediate family member.

3. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies; I will inform my physician in advance. The pharmacy I select MUST be able to accept electronic prescriptions. The pharmacy I am selecting is:

Name:

Address:

Phone Number:

4. I will inform MMP's office of any new medications or medical conditions, and of any adverse effects 1 experience from any of the medications that I take.

5. I agree that my prescribing physician/nurse practitioner has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.

6. I will not allow anyone else to have, use, sell, or otherwise have access to these medications.

7. I understand that tampering with a written prescription is a felony. I will not change or tamper with my physician's/nurse practitioner's written prescription.

8. I will take my medication as prescribed and I will not exceed the maximum prescribed dose.

9. I understand that these drugs should not be stopped abruptly, as withdrawal symptoms will likely develop.

10. I will cooperate with unannounced urine or serum toxicology screens as may be requested.

11. I understand that the presence of unauthorized substances may prompt referral for assessment fora substance abuse disorder or discharge from treatment with MMP.

12. I understand that these drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety.

13. I understand that these medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication I will be required to complete a statement explaining the circumstances. In the event I report them stolen, a police report will be required. At that time a determination will be made as to whether I may receive an early refill. If I request an early refill secondary to lost, damaged, or stolen prescriptions twice within one year | may be discharged from treatment with MMP.

14. I understand that a prescription may be given early if the physician/nurse practitioner or patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescription(s) may not be filled prior to the appropriate date.

15. If the responsible legal authorities have questions concerning my treatment, as may occur, for example if I obtained medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to my records of controlled substances administration.

16. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by MMP or referral for further special treatment.

17. *** I will keep my scheduled appointments in order to receive medication renewals. NO REFILLS WILL BE GIVEN OVER THE PHONE, VIA FAX, ON SHORT NOTICE, AT NIGHT, OR ON WEEKENDS. ***

18. I understand that medical treatment at MMP is initially a trial and that continued prescription is contingent on whether my physician/nurse practitioner believes that the medication usage benefits me.

19. I have been explained the risks and potential benefits of these therapies, including, but not limited to psychological addiction, physical dependence, withdrawal, and overdose.

20. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand, and accept all of its terms.

21. I am aware that attempting to obtain a controlled substance under false pretenses is illegal and I will be discharged from treatment at Midwest Medical Practitioners, LLC.

_____	_____
Patient Name (Printed)	Physician/APRN Name (Printed)
_____	_____
Patient Signature	Physician/APRN Signature
_____	_____
Date	Date

APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Midwest Medical Practitioners. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

Effective January 1, 2023, ANY new or established patient who fails to show or cancels an appointment and has not contacted our office with at least 24 hours notice will be considered a NO SHOW and charged a $25.00 fee. This policy applies to Televisits too.

- After a second NO SHOW, the patient will be charged a $50.00 fee.
- After a third NO SHOW, the patient will be dismissed from Midwest Medical Practitioners.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- Any new patient who reschedules their initial visit 2 times will not be rescheduled for a 3rd time.
- Late arrivals: If you are 15 minutes or more late to your appointment, we will reschedule your appointment, but you will be considered a NO SHOW.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit. Failure to pay the fee upon arrival, may result in cancellation of your appointment and future appointments

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office Manager, who may be able to waive the No Show fee.

Signature_____ Date_____

PATIENT NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996-(HIPAA), Health Information

Technology for Economic and Clinical Health Act (HITECH Act), and associated regulations and amendments:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEWII CAREFULLY

If you have any questions about this notice or if you need more information, please contact: Midwest Medical Practitioners ATTN: Danish A. Jabbar, M.D. Privacy Officer 1153 E Gannon Drive, Festus 636-282-0380

ABOUT THIS NOTICE We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive at all divisions of Midwest Medical Practitioners. We need this record to provide care and treatment, to calculate payment of care provided and health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

WHAT IS PROTECTED HEALTH INFORMATION? (PHIM PHI is information that individually identifies you. We create a record or get one from you or from another health employer, or a healthcare clearinghouse that relates to:

• Your past, present, or future physical or mental health or conditions, - The provision of health care to you, or

•The past, present, or future payment for your health care. CIRCUMSTANCES WHEN WE MAY USE AND DISCLOSE YOUR PHI:

• Treatment. We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care, For example, your PHI may be provided to a physician or other health care provider (e.g. a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

• Payment. We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligiblity or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment. - Health Care Operations. We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We may also disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

• Appointment Reminders/Treatment AlternativesiHealth-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- Minors, We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

• Research. We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of any PHI, We may discose PHI to be used in collaborative research initiatives amongst Midwest Medical Practitioners providers. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

• As Required by Law. We will disclose PHI about you when required to do so by international, federal, state, or local law.

• To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others, but we will only disclose the information to someone who may be able to help prevent the threat.

Business Associates. We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.

• Organ and Tissue Donation. If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation such as an organ donation bank- as necessary to facilitate organ or tissue donation and transplantation.
• Military and Veterans, if you are a member of the armed forces, we may disclose PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military. - Workers Compensation. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
• Public Health Risks. We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration (FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reacgtions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition, *Abuse, Neglect, or Domestic Violence. We may disclose PH to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
• Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to inform you of the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.
• Data Breach Notification Purposes. We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information,
• Law Enforcement. We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.
• Military Activity and National Security. If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your PHI to authorized officials so they may carry out their legal duties under the law.
Coroners, Medical Examiners, and Funeral Directors. We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.
• Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care: (2) to protect your health and safety or the health and safety of others: (3) the safety and security of the correctional institution. USES AND DISCLOSURES THAT REQUIRE US TO GIVE YQU AN OPPORTUNITY TO OBJECT AND OPI OUT: - Individuals Involved in Your Care. Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
• Payment for Your Care. Unless you object in writing, you can exercise your rights under HIPAA that your healthcare provider not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.
• Disaster Relief. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so. * Fundraising Activities. We may use or disclose your PHI, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. OTHER USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION: The following uses and disclosures of your PHI will be made only with your written authorization; * Most uses and disclosures of psychotherapy notes:
• Uses and disclosures of PHI for marketing purposes; and
Disclosures that constitute a sale of your PHI. 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. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. Disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation. YOUR RIGHTS REGARDING YOUR PHI: You have the following rights, subject to certain limitations, regarding your PHI:
• Inspect and Copy. You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care, We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. You can only direct us in writing to submit your PHI to a third party not covered in this notice. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the deriial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Summary or Explanation. We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees. - Electronic Copy of Electronic Medical Records, if your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the PHI is not readily producible in the form or format you request your record will be provided in a readable hard copy form.

Receive Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured PHI. - Request Amendments. If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend tne information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment If we deny your request for an 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. * Accounting of Disclosures. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period. We may charge you for the reasonable costs of providing the list. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

• Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure: and to whom you want the restriction to apply.

• Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.

• Paper Copy of This Notice. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice by contacting the Midwest Medical Practitioners office. . Changes to This Notice. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have, as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website, *Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Midwest Medical Practitioners Privacy Officer at the address listed at the beginning of this Notice or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Secretary. mail it to: Secretary of the U.S. Department of Health and Humans Services, 200 Independence Ave., *S*.W., Washington, D.C. 20201. Call (202) 619-0257 (or loll

free *(8*77) 696-6775 or go to the website of the Office for Civil Rights, www.hhs.go*víocri*hipaal, for more information, You will not be penalized for filing a complaint.

Notice Effective 11/24/2021

MIDWEST MEDICAL PRACTITIONERS

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

My signature below indicates that I have reviewed, understand and give my consent for Midwest Medical Practice (MMP) to use and disclose my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO) as outlined in the Patient Notice of Privacy Practices.

I have carefully reviewed the Notice of Privacy Practices prior to signing this consent. Midwest Medical Practitioners reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to either address below:

Midwest Medical Practitioners
ATTN: D.A. Jabbar, M.D., Privacy Officer
1153 East Gannon Drive Festus, MO 63028

With this consent, Midwest Medical Practitioners may email, mail or call my home or other alternative location and speak to me or leave a message on voice mail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, patient statements, among others, as long as they are marked "Personal and Confidential." .

I have the right to request that Midwest Medical Practitioners restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Midwest Medical Practitioners may decline to provide treatment to me.

Signature of Patient or Legal Guardian _____

Printed Name of Patient or Legal Guardian _____

Date: _____

PATIENT AFFIRMATION

(PLEASE INITIAL EACH ONE)

_____I HAVE PROVIDED A COMPLETE AND CORRECT LIST OF MY MEDICATIONS AT THE TIME OF INTAKE .

_____I CONFIRM THAT I DO NOT HAVE ANY OTHER CONTROLLED MEDICATIONS THAT I HAVE NOT DECLARED.

_____MY PRESCRIPTION MEDICATION WILL BE GIVEN BASED ON THE DOCTORS EVALUATION ONLY.

_____I CONFIRM ANY ABUSIVE OR THREATENING BEHAVIOR WITH THE STAFF WILL RESULT IN IMMEDIATE TERMINATION FROM THE PRACTICE,

_____I WILL USE ONLY ONE PHARMACY FOR MY PRESCRIPTIONS THAT WILL BE SENT ELECTRONICALLY.

Optional

THIS OFFICE PARTICIPATES IN ELECTRONIC STATEMENTS. IF YOU WOULD LIKE TO OPT OUT AND RECEIVE PAPER STATEMENTS, INITIAL HERE _____

Danish A. Jabbar, MD **Lacy Hosay, FNP-BC**
Amanda Balk, PA **Angie Adams, FNP-BC**
Karam Abdelmasih, AP

1153 E Gannon Dr. Festus, MO 63028
120 Boyd St. DeSoto, MO 63020

PH: 636-282-0380 FAX: 877-592-0806

Card on File Agreement (Optional)

We have implemented a new policy, which enables you to maintain your credit card information on file in our office. This new policy is completely optional; it is simply for the convenience of our patients and our staff when payment is needed.

If you choose to keep your card on file, please know that the information will be kept confidential and secure within our EMR system. Once your card has been added into your chart, our staff will **only** be able to see the last 4 digits, expiration date, and type of card (Visa, Mastercard, etc).

You will only be able to maintain one card on file at a time. If you wish to change the card on file, you will be asked to re-sign this agreement with the updated card information entered below.

You can delete your card at any time. Please note that once the card on file is deleted, our staff will not be able to re-activate the card within the system. To re-add a card, you will need to provide the card information again.

By signing below, I authorize Midwest Medical Practitioners to keep my credit card information securely on file in my account. This card will only be charged upon **my request**.

Name (Printed): _____ DOB:_____

Signature:_____ Date:_____

Last 4 digits of card: _____ Expiration Date:_____

Midwest Medical Practitioners
Personalized Primary care

We have exciting news regarding your health care!

We are proud to announce that our practice now offers you the opportunity to track aspects of your health care through the **Healow Patient Portal.** The patient portal enables patients to communicate with our practice easily, safely, and securely over the internet.

Sign up for our patient portal today!

https://healow.com/apps/jsp/webview/signIn.jsp

Practice code: IJJBCD

Accepting New Patients!

Just scan this QR code with the camera on your phone to be taken directly to the app download.

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Health And Online Wellness

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