SLIP-AND-FALL (Liability) PATIENT REGISTRATION

Today's Date: _____ Name: _____ DOB: _____ SSN#: _____

Gender: □ *Male* □ *Female* Marital Status: □ *Married* □ *Single* □ *Divorced*

Street Address: _____City: _____ State: ___ Zip Code: ____

Mobile phone: _____ Home phone: _____ Alternate phone: _____

Email: _____

Emergency Contact Name: _____ Relationship:_____ Phone: _____

Height: _____ Weight: _____

Do you smoke? □ *Yes* □ *No* If Yes, how much? _____

Do you consume alcohol? □ *Yes* □ *No* If Yes, how often? _____

Attorney Name: _____

Current Employment Status: □ *Full time* □ *Part time* □ *Retired* □ *Student* □ *Home maker*
□ *Unemployed* □ *Disabled* □ *Self-employed*

Most Recent Occupation: _____ Employer: _____

Employer Address: _____

Date of Injury: _____ Insurer: _____

Adjuster Name: _____ Phone#: _____ Claim#: _____

Health Insurance Carrier: _____ Subscriber ID: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Do you have Medicare? □ *Yes* □ *No* Do you have Medicaid? □ *Yes* □ *No*

Describe the reason for today's visit in detail (how the injury incurred, where, when, ER visit, treatment at ER, out of work due to injury, any prior injury, etc):

_____

_____

_____

_____

_____

_____

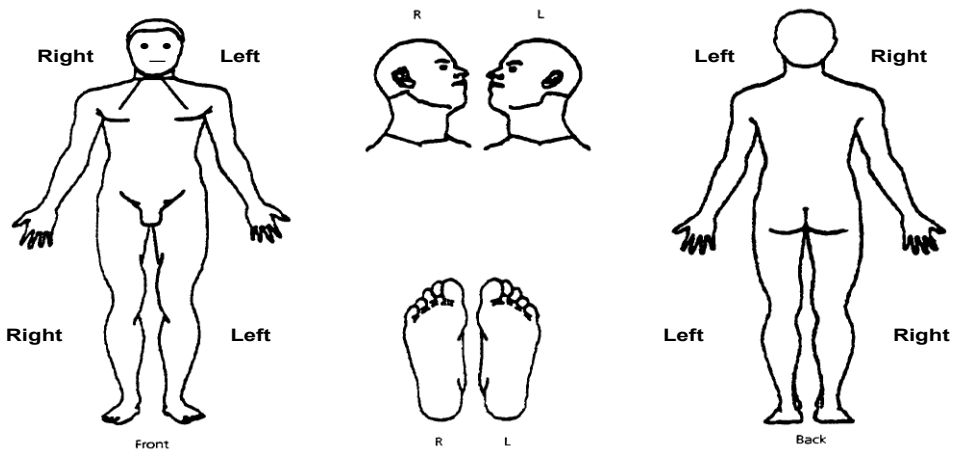
_____

_____

_____

Are you pain free prior to injury? [ ] Yes [ ] No

Location of Pain: Please shade in the painful areas in the diagram below. Put "x" on areas of tingling, "o" on burning areas, and "*" on areas with no feeling at all.



Least Pain level (0 being the least amount of pain): 0 1 2 3 4 5 6 7 8 9 10

Worst Pain level (0 being the least amount of pain): 0 1 2 3 4 5 6 7 8 9 10

Which of the following make your pain feel worse? Check all that apply.

□ *Sitting* □ *Standing* □ *Walking* □ *Lying down* □ *Bending forward* □ *Bending backwards*
□ *Morning hours* □ *Evening hours* □ *Coughing, Sneezing* □ *Damp weather*
□ *Physical therapy* □ *Getting out of bed* □ *Stress*□ *Other:*_____

Which of the following make your pain feel better? Check all that apply.

□ *Sitting* □ *Standing* □ *Walking* □ *Lying down* □ *Bending forward* □ *Bending backwards*
□ *Morning hours* □ *Evening hours* □ *Relaxation* □ *Physical therapy* □ *Acupuncture*
□ *Heat* □ *Ice pack* □ *Chiropractic treatment* □ *Other:*_____

Please list treatment and provider you had for your pain:

□ *Over the counter Pain Killer (such as Motrin, Advil, Aspirin, Aleve, Tylenol)*
□ *Chiropractic (How long? _____ Doctor/Facility? _____)*
□ *Physical Therapy (How Long? _____ Doctor/Facility? _____)*
□ *Acupuncture (How long? _____ Doctor/Facility? _____)*
□ *Surgery (What surgery? _____ Doctor/Facility? _____)*
□ *Pain Injections (such as epidurals, facet injections, joint injections, etc)*

□ *Other:* _____

Please check and list your past medical history: □ ***None***

□ *Heart Problem (Heart Attack, Stroke, CAD, Arrhythmia, Atrial Fibrillation, Stent, _____)*

□ *Hypertension* □ *High Cholesterol* □ *Diabetes* □ *Asthma* □ *Lung disease (COPD)* □ *Seizure*

□ *Hyperthyroidism* □ *Hypothyroidism* □ *GI disease (GERD)* □ *Kidney disease*

□ *Depression* □ *Anxiety Disorder* □ *Osteoarthritis* □ *Rheumatoid Arthritis* □ *Fibromyalgia*

□ *Migraine Headache* □ *Chronic Low Back Pain* □ *HIV* □ *Hepatitis B or C*

_____

_____

Primary Care Doctor Name: _____ Phone#: _____

Cardiologist (Heart) Name: _____ Phone#: _____

Neurologist (Seizure) Name: _____ Phone#: _____

Pulmonologist (Lung) Name:_____ Phone#: _____

Endocrinologist (Thyroid) Name: _____ Phone#: _____

Please check and list your past surgical history year: □ ***None***

□ *Back Surgery* □ *Neck Surgery* □ *Heart Surgery* □ *C-Section* □ *Eye Surgery*

_____

_____

_____

Do you have any allergies (food and medicine)? □ ***Yes*** □ ***No*** **If Yes, please list _____**

Please list MEDICATIONS with dosage and frequency you are taking: □ ***None***

_____

_____

_____

_____

_____

Are you taking blood thinners?

□ *Yes (□ Aspirin* □ *Plavix* □ *Coumadin/Warfarin* □ *Other_____)* □ *No*

Are you taking Benzodiazepine (i.e. valium, ativan, klonopin)?

□ *Yes* □ *No*

Note To Patients: For your safety, you MUST inform our providers ANY medication changes every time you see our providers.

Signature_____ Date_____

CONSENTS AND DISCLOSURE

Patient name: _____ Date: _____

ASSIGMENT OF BENEFITS AND INSURANCE AUTHORIZATION

I hereby authorize WeCare Medical Specialty Group to furnish information to insurance carriers concerning my illness and treatments and bill insurance carriers on behalf of me using my out of network benefit. I hereby assign all payments, for medical services rendered to myself or my dependent, unconditionally to WeCare Medical Specialty Group. I do understand that I am responsible for any amount not covered by my insurance and that should my insurance company send the payment to me, I will forward the payment within 48 hours to WeCare Medical Specialty Group.

Patient Signature:_____

CONSENT TO APPEAL AND ARBITRATION OF DENIAL

I hereby authorize WeCare Medical Specialty Group to file appeal and arbitration with my insurance carrier on behalf of me in case of denial of service and payment.

Patient Signature:_____

NO FAULT AND/OR WORKER'S COMPENSATION PATIENTS *ONLY*

I hereby authorize the release of my medical chart, bills and/or any other information related to my treatment, to my attorney _____. I further authorize WeCare Medical Specialty Group to pursue payment of my bills. I understand that all medical bills will be submitted to the responsible insurance carrier and will only be submitted to my medical insurance carrier in the event that payment is denied and/or there is remaining balance which I am responsible for. I understand that I am directly and fully responsible for all medical bills and if needed your attorney will arbitrate my bills for payment. I acknowledge that WeCare Medial Specialty Group and its providers do not participate in Medicaid and do not accept Medicare fee schedule for injury cases.

Patient Signature:_____

HIPPA PRIVACY ACKNOWLEDGEMENT

I acknowledge that I have been provided with a copy of WeCare Medical Specialty Group privacy notice, which is effective as of today's date.

Patient Signature:_____

DISCLOSURE

We wish to inform you that the doctor of WeCare Medical Specialty Group does have a financial interest in: *Surgicore Surgery Center*, *Manalapan Surgery Center, Union Surgery Center, and ICMISS*. You may, of course, choose to have your treatment at any of the health care facilities that we participate with.

Patient Signature:_____

CONTROLLED SUBSTANCE AGREEMENT AND INFOMED CONSENT

I acknowledge that I have been informed of WeCare Medical Specialty Group clinic policy and agreement on controlled substance and agree to abide the terms if I am placed on the controlled substances. Any violation of the clinic policy and agreement may cause termination of medication therapy at the discretion of my physician.

Patient Signature:_____

IRREVOCABLE PHYSICIAN'S LIEN

Patients Name: _____

Accident Date: _____

For and in consideration of the professional services I am about to receive or am receiving from you (WeCare Medical Specialty Group), to the extent of your unpaid charged.

I hereby grant you a voluntary and irrevocable lien against my share of the proceeds of any settlement or award resulting from the disposition if any claim which I may have arising from the captioned accident in which I was involved.

I hereby direct any attorney to recognize and honor this lien and to pay you directly from the proceeds allocated to me in this attorney trust account at the time he receives them.

I hereby acknowledge that WeCare Medical Specialty Group and its providers do not participate in Medicaid and Medicare and do not accept Medicare fee schedule for injury cases.

I have personally served my attorney with a copy of this lien and as principal have put my attorney, as my agent on notice regarding his responsibility is paying you.

I hereby agree never to rescind or amend this lien and hereby agree to release you and my attorney from any claims whether in law or at equity which I may have resulting from the interpretation of this lien.

Should there be no settlement or award, I agree to remain personally responsible to pay your charges. If my account goes to collection, I will be responsible for the attorney fees and collection charges.

Signature of Patient: _____Date: _____

OFFICE PROCEDURE INFORMED CONSENT TO TREAT

You have a pain problem that has not been relieved by routine treatments. A procedure, specifically an injection or operation, is now indicated for further evaluation or treatment of your pain. There is **NO guarantee** that a procedure will cure your pain, and in rare cases, **it could become WORSE**, even when the procedure is performed in a technically perfect manner. The degree and duration of pain relief varies from person to person, so after your procedure, we will reevaluate your progress, then determine if further treatment is necessary. Your physician will explain the details of the procedure listed below.

Tell the physician if you are taking any blood thinners such **as PLAVIX, Aspirin, Coumadin, Lovenox or HEPARIN**, as these can cause excessive bleeding and a procedure should **NOT** be performed. Alternatives to the procedure include medications, physical therapy, acupuncture, surgery, etc. Benefits include increased likelihood of correct diagnosis and /or of decrease or elimination of pain. **Risks include infection, bleeding, allergic reaction, increased pain; nerve damage involving temporary or permanent pain, numbness, weakness, paralysis or death; air in lung requiring chest tube; tissue, bone or eye damage from steroids.** Nerve destruction with radiofrequency energy has risks of nerve and tissue damage. Specific risks pertaining to each specific procedure are as follows (patient to initial line of procedure):

The incidence of serious complications listed above requiring treatment is low. Your physician believes the benefits of the procedure outweigh its risks or it would not have been offered to you, and it is your decision and right to accept or decline to have the procedure done. **I have read or had read to me** the above information including the Pre-Procedure Patient Instruction page. I **UNDERSTAND** there are risks involved with spinal procedure, to include rare complications, which may not have been specifically mentioned above. **The risks have been explained to my satisfaction and I accept them and consent to any procedure**. I also understand that one of the greatest risks involved with pain management procedures involves various medications taken, allergies and my general medical condition. I will inform the doctor of any blood thinning medication taken or any changes in other medications, allergies or medical condition prior to any procedure.

By voluntarily signing below, I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

X _____ X_____ _____
Patient Name Patient or his/her legal guardian Date

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the providers who perform acupuncture treatment at the clinic whether signatories to this form or not. I have been informed that acupuncture is a generally safe method of treatment but that it may have some side effects, including but not limited to bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, organ puncture and infection.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

X _____ X_____ _____
Patient Name Patient or his/her legal guardian Date

PATIENT AUTHORIZATION FORM

Patient Name: _____ DOB: _____

Claim#: _____

I hereby request and authorize my auto insurance carrier to release my auto insurance information and health record to WeCare Medical Specialty Group. The information includes but is not limited to:

1) **Medical Records**

I hereby also request and authorize my healthcare carrier, my treating physician and doctor, and lab to disclose, make available and furnish to WeCare Medical Specialty Group all information including: healthcare insurance, medical records, X-rays, MRI report, IME report and/or copies thereof related to my examination, confinement of treatment and to permit WeCare Medical Specialty Group to inspect and make copies, or abstracts thereof.

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Please send the records by fax, mail or email to:

2040 Millburn Ave #201, Maplewood, NJ 07040

Phone: 973-996-2990 Fax: 908-242-3911

Email: officemanager@wecaremedical.us

I further understand this authorization is voluntary and that I may refuse to sign this authorization. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information to WeCare Medical Specialty Group.

Patient Signature: _____ Date: _____

NON PARTICIPATING HEALTHCARE WAIVER

Please be advised that providers at WeCare Medical Specialty Group are non-participating providers of your insurance. The insurance company will not accept our assignment of benefits, therefore all payments are sent directly to the patient.

Any payments received by you from insurance must be immediately endorsed and returned to service provider along with explanation of benefits. Failure to do so may result in late payment penalties, interest and legal actions. I assume full responsibility for the entire DOS if I do not sign and return any payment received by me to the servicing provider.

Signature of Patient/Guardian: _____

Print Name: _____

MEDICAID AND MEDICARE CONSENT FORM

Do you have Medicaid? Yes [ ] No [ ]

Do you have Medicare? Yes [ ] No [ ]

I acknowledge that WeCare Medial Specialty Group and its providers do not participate Medicaid and Medicare and do not accept Medicare fee schedule for injury cases.

Signature of Patient/Guardian: _____

Print Name: _____

Designation of Authorized Representative / Authorization Form

Part A: Insurance and Member Information			
Insurance Carrier			
Member Name	Date of Birth	Member ID	
Member Street Address	City	State/ZIP	Phone

Part B: Person or company who can act as my Authorized Representative

The following person or company has the right to act as my Authorized Representative. An Authorized Representative is a person or company who you appoint to be your representative in carrying out a grievance or appeal, including any external review rights that may be available to you. They must be 18 years of age or older.

Name of Authorized Representative			
Representative Street Address	City	State/ZIP	Phone

Part C: Information that can be released

I allow all my information to be used or released by my insurance carrier on my behalf. My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information.

Part D: Review and approval

I have read the contents of this form. I understand, agree, and allow my insurance carrier to the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that my insurance carrier does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to my insurance carrier. I understand that my withdrawing of this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member or Designated Legal Representative/Guardian Signature	Date
X	

Controlled Substance Agreement and Informed Consent Form
(please sign with your initial on each page)

The following agreement relates to my use of controlled substances including but not limited to "narcotics/opioids," to treat chronic pain. I will be provided with prescriptions only if I understand and agree to the following:

1. I understand that, depending on the drug and dose, I can become physically dependent on the medication and can develop withdrawal symptoms if the medication is stopped suddenly or the dose reduced rapidly. Although the risk is small there is a chance of developing an addiction to controlled substances if I am placed on them to help control my pain.

2. Controlled substances can cause sedation, confusion, or other changes in mental state and thinking abilities. I understand that the decision to drive while I am taking controlled substances is my own decision, and I agree not to be involved in any activity that may be dangerous to me or someone else such as driving or operating any dangerous equipment, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself if I am in any way sedated, feel drowsy or a not thinking clearly.

3. I will not use any illegal controlled substances including, but not limited to, marijuana and cocaine. I will not drive while intoxicated with alcohol.

4. The WeCare Medical Specialty Group policy regarding the dispensing of controlled substances requires that I be seen regularly and I agree to make and keep my appointments. I will advise my doctor of all other medicines and treatments that I am receiving.

5. If the medication requires adjustment, an appointment must be made to see the doctor. No adjustments will be made over the telephone. My careful planning is required. I understand that medication refills and adjustments are done during office appointments except under very unusual circumstances. I must stay with the prescribed dosing so that I do not run out of medication early. The medication is expected to last until the date that is found on the bottom of the prescription. I understand that the WeCare Medical Specialty Group policy is not to prescribe early. I agree that I will use my medication exactly as prescribed and that if I run out early, I may go without medication until the next prescription is due, possibly resulting in withdrawal symptoms.

6. I understand that the prescriptions are my responsibility once they are placed in my hand and that if anything happens to my prescription (lost, stolen, accidentally destroyed), I may not receive a replacement from my physician. WeCare Medical Specialty Group expects me to file a police report if my medication is stolen. I will be prepared to bring in a copy at my next office visit.

7. My physician will prescribe whatever medication he/she is comfortable with and thinks best; he/she is not under any obligation to prescribe any specific medication.

8. I am aware of the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included: injections, therapy, and surgery (if indicated).

9. I agree to come to the WeCare Medical Specialty Group with my medication on the same day that I am called and submit to a pill count, and/or urine or blood screening to detect illegal substances or confirm proper use of prescribed medicine. The call to come to the WeCare Medical Specialty Group can be made either randomly, or if a concern arises. I may be required to bring my unused medication routinely to each office visit. If I do not have insurance or my insurance denies testing, I will be responsible for the cost of the test.

10. I give permission to the WeCare Medical Specialty Group staff to call any pharmacy or another health care provider at any time, without my being informed, to discuss my past or present use of controlled or illegal substances.

11. I will not use my pain medication in higher than prescribed amounts for new problems that arise

(toothache, surgery, etc.) unless authorized to do so. I will inform my other doctor(s) of my use of medication for chronic pain, and I will inform the WeCare Medical Specialty Group staff if another physician prescribes controlled substances for the acute problem. My doctor at WeCare Medical Specialty Group is my primary doctor with regard to my pain medications. If there is a medical emergency (e.g. broken leg, surgery requiring post-op pain medication, dental procedures, etc.), another doctor may prescribe pain medication to me, but I will advise the prescribing doctor of my care at WeCare Medical Specialty Group, authorize the doctor to disclose information to WeCare Medical Specialty Group, and I will also notify my doctor at WeCare Medical Specialty Group of the medication and dosage.

12. (Females only) Because of the risks of certain medications to unborn children, I will inform all physicians, obstetrician/ gynecologist and WeCare Medical Specialty Group, immediately if I become pregnant or decide to try to become pregnant. I am aware that should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware the use of opioids is not generally associated with risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

13. (Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

14. My physician can wean me off of controlled substances at any time if he/she feels that it is in my best interest. The weaning process can result in withdrawal symptoms. If I am weaned off, the WeCare Medical Specialty Group staff may inform my other health care providers as to the reasons for the weaning.

15. Abstinence Syndrome (Withdrawal Syndrome): Stopping my opioid, antiseizure or antidepressant medication abruptly may result in withdrawal symptoms (flu-like symptoms, GI distress, diarrhea, sweating, heart palpitations, and rarely seizures or death). I should wean from my medications rather than stopping them abruptly. If I find myself without medication, I will use the emergency line to notify my doctor.

16. I understand that in general I may be weaned off of my medication or my drug therapy may be terminated at the discretion of my physician if any of the following occur:a)It is the opinion of my physician that controlled substances are not very effective for my pain and/or my functional activity is not improved.b)I misuse the medication.c)I develop rapid tolerance or loss of effect from this treatment.d)I develop side effects that are significant and detrimental to me.e)I obtain controlled substances from sources other than my WeCare Medical Specialty Group physician without informing him or her.f)Pill counts or test results indicate the improper use of the prescribed medication or the use of other drugs, and/or I fail to submit to such counts/tests on the day that I am called.g)I am arrested and/or convicted for a controlled or illicit drug violation including drunk driving.h)Any violation of this agreement.

17. I further understand that my drug therapy will be terminated or detoxification in a controlled environment will be required if I give away, sell, distribute and/or transport with the intent to sell or dispense my medication.

18. I choose to use _____ Pharmacy, located at _____, for all of my pain medication prescriptions. I will not fill partial prescriptions, if my pharmacy does not stock the full quantity of medication. If I change my pharmacy for any reason, I agree to notify my pain physician.

I have read the above Agreement, understand the Agreement, have had all my questions concerning this Agreement answered to my satisfaction, and I agree to abide by the terms of this Agreement if I am placed on controlled substances (including, but not limited to narcotic analgesics). I have received a copy of the Agreement. By signing this form voluntarily, I give my consent for the treatment of my pain with narcotic/opioid pain medicines.

_____ _____

Patient Date

Your Rights and Protections Against Surprise Medical Bills

Federal No Surprises Act Disclosure Notice

When you receive emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from certain unexpected medical bills, also known as surprise bills.

What is balance billing?

When you receive care from a provider who does not participate in your health insurance network, that provider may ordinarily charge more than your insurance plan's allowed amount. The difference between the provider's charge and the amount paid by your insurance plan is called balance billing. Federal law prohibits balance billing in certain circumstances.

Your protections at an in-network surgical center

- You generally cannot be billed more than your applicable in-network deductible, copayment, or coinsurance for protected services.
- Your insurance plan must generally calculate your cost-sharing responsibility using the applicable in-network rules.
- Your out-of-network physician cannot bill you for the difference between the physician's charges and the amount paid by your insurance plan for protected services.
- You cannot be required to waive your federal balance-billing protections.

For certain nonemergency services, an out-of-network provider may request your written consent to waive these protections, subject to strict federal requirements. You are never required to give that consent.

Your rights under federal law

You are protected against prohibited balance billing under the No Surprises Act. If you believe you have been incorrectly billed, contact the Centers for Medicare & Medicaid Services (CMS) at 1-800-985-3059 or www.cms.gov/nosurprises.

For additional information about your rights under New Jersey law, you may also contact the New Jersey Department of Banking and Insurance.

This notice informs patients of their rights under federal law. It is not a waiver of those rights and does not authorize out-of-network balance billing.

NOTICE OF PRIVACY PRACTICES

Effective date: October 5th, 2026

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.

WeCare Medical Specialty Group ("WeCare," "we," "our") is required by law to maintain the privacy and security of your protected health information (PHI), to provide this notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect. We will notify affected individuals following a breach of unsecured PHI as required by law.

Your rights

Access your records

You may inspect or obtain an electronic or paper copy of medical and billing records and other PHI in our designated record set, subject to limited legal exceptions. We generally respond within 30 days; if a permitted extension is needed, we will notify you in writing. We may charge a reasonable, cost-based fee as permitted by law. You may also ask us to transmit an electronic copy to a designated third party where applicable.

Request corrections

You may ask us to amend information you believe is incorrect or incomplete. We generally respond within 60 days and will explain in writing if we deny the request. A permitted extension may apply.

Request confidential communications

You may request that we contact you by a particular method or at another address. We will accommodate reasonable requests without requiring you to explain your reason.

Request restrictions

You may ask us to limit uses or disclosures for treatment, payment, or health care operations. We generally are not required to agree, except that when you pay in full out of pocket for an item or service and request that we not disclose related information to your health plan for payment or health care operations, we must honor the restriction unless disclosure is required by law. Tell our Privacy Officer when requesting a restriction.

Accounting of disclosures

You may request an accounting of certain disclosures of your PHI made during the six years before your request, subject to exclusions under HIPAA. One accounting in any 12-month period is free; additional requests may incur a reasonable, cost-based fee.

Paper copy and personal representatives

You may request a paper copy of this notice even if you agreed to electronic delivery. A legally authorized personal representative may exercise your rights, subject to applicable law and verification of authority.

File a complaint

You may complain to our Privacy Officer or to the U.S. Department of Health and Human Services, Office for Civil Rights, at https://www.hhs.gov/hipaa/filing-a-complaint/ or 1-877-696-6775. We will not retaliate against you for filing a complaint.

Your choices and authorizations

You may tell us your preferences about sharing relevant information with family, friends, or others involved in your care or payment, and about disaster relief. If you cannot tell us your preference, we may share information when permitted by law and consistent with your best interests. WeCare does not operate a hospital patient directory; if that changes, applicable directory choices will be explained.

Except as otherwise permitted by law, we will obtain your written authorization for uses or disclosures for marketing, sale of PHI, and most uses or disclosures of psychotherapy notes. You may revoke an authorization in writing, except to the extent we have already acted in reliance on it. If we conduct fundraising communications, you may opt out of future fundraising contacts.

How we use and disclose health information

Treatment, payment, and health care operations

Treatment: We may share information with physicians, surgery centers, therapists, laboratories, and other professionals involved in your care, including referrals and care coordination.

Payment: We may share information with insurers, billing services, claims administrators, and other appropriate parties to determine coverage, obtain authorization, bill, collect payment, and address claims, appeals, and payment disputes.

Health care operations: We may use information for quality improvement, credentialing, audits, compliance, staff training, business management, and related lawful operations. Business associates handling PHI on our behalf are subject to required written safeguards.

Other uses and disclosures permitted or required by law

Subject to applicable legal conditions, we may use or disclose PHI for public health reporting; reporting abuse or neglect; health oversight; product safety and recalls; research; organ or tissue donation; coroners and funeral directors; workers' compensation; law enforcement and judicial proceedings; military or national security functions; correctional settings; averting a serious threat to health or safety; and other uses required by federal or state law. We may disclose PHI to HHS to demonstrate compliance with HIPAA. Some disclosures require additional safeguards, authorization, or legal process. New Jersey law may provide additional protections.

Specially protected substance-use-disorder records

WeCare does not operate a substance-use-disorder treatment program. However, if we receive or maintain patient records protected by 42 CFR Part 2 from another provider, we will comply with applicable additional restrictions. Such records may not be used or disclosed in civil, criminal, administrative, or legislative investigations or proceedings against the patient without the patient's specific written consent or an appropriate court order accompanied by required legal process, as permitted by Part 2. Other uses or redisclosures are subject to applicable Part 2 and HIPAA

requirements. If fundraising would use Part 2 information, we will provide any required advance notice and opportunity to opt out.

Our responsibilities and changes to this notice

We safeguard your information and notify you if a reportable breach of unsecured PHI occurs. We will not use or share information other than as described here unless you authorize it or the law allows or requires it. We may change this notice and apply the revised terms to PHI we already maintain. A current copy will be available at our office, on our website if applicable, and upon request.

Questions, requests, and complaints

Privacy Officer, WeCare Medical Specialty Group

Telephone: (973) 996-2990

Email: info@wecaremedical.us

Please contact the Privacy Officer to request records, amendments, restrictions, confidential communications, an accounting, or a paper copy of this notice.