PRECISION ENDOCRINOLOGY

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

PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR PRIVACY OFFICER AT 940-488-4767.

This Notice of Privacy Practices describes how MEDICAL GROUP NAME, ("Practice") may use and disclose your protected health information to carry out your treatment, payment for your health care, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related to health care services. We are required to maintain the privacy of protected health information and to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time.
Upon your request, we will provide you with any revised Notice of Privacy Practices via our website, www.endont.com, or by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. An updated copy will also be posted in your Practice Physician's office.

1. Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the Practice. Following are examples of the types of uses and disclosures of your protected health care information that the Practice is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our Practice.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a radiologist or pathologist) who, at the request of your attending physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to the Practice or
your physician.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. This 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 eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or
disclose, as-needed, your protected health information in order to support the professional and business activities of the Practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical and nursing students, licensing, and conducting or arranging for other business activities.
For example, we may disclose your protected health information to medical and nursing school students that see patients at our Practice. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and provide other requested information. We may also call you by name in the waiting room when you are ready to be seen. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We will share your protected health information with third party Business Associate or Business Associate sub-contractor, or any affiliate of PE with whom we share information; to perform various activities (e.g., billing, transcription services, telephone answering services, etc.) for the Practice. We may use or disclose your protected health information, as necessary, to provide you with appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, we may send you that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

EMERGENCIES: We may use or disclose your protected health information in an emergency treatment situation.

Other Permitted and Required Uses and Disclosures That May Be Made without Your Authorization or Opportunity to Object.
We may use or disclose your protected health information in the following situations without your authorization. These situations include:

REQUIRED BY LAW: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The

use information about products or services that we believe may be beneficial to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization.
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law, as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the Practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object.

You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician or the Practice may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed. We may use and disclose your protected health information in the following instances:

OTHERS INVOLVED IN YOUR HEALTHCARE:
Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information 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

Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the Practice. Following are examples of the types of uses and disclosures of your protected health care information that the Practice is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our Practice.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You may be notified, as required by law, of any such uses or disclosures.

ELECTRONIC HEALTH INFORMATION EXCHANGE:
PE participates in an electronic health information exchange. The exchange allows PE to share information with other providers and to receive health information from other providers so that you can receive better care. You have the right to ask PE not to share your health information through the exchange.

BREACH NOTIFICATION: We will notify affected individuals of breach of unsecured PHI.

PUBLIC HEALTH: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

COMMUNICABLE DISEASES: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

HEALTH OVERSIGHT: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

ABUSE OR NEGLECT: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

FOOD AND DRUG ADMINISTRATION: We may
disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

LEGAL PROCEEDINGS: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

LAW ENFORCEMENT: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice Physician's premises) and it is likely that a crime has occurred.

CORONERS, FUNERAL DIRECTORS, AND ORGAN DONATION:
We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

RESEARCH: If you choose to participate in medical or scientific research, we may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

CRIMINAL ACTIVITY: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

MILITARY ACTIVITY AND NATIONAL SECURITY:
When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

WORKERS' COMPENSATION: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally- established programs.

INMATES: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

REQUIRED USES AND DISCLOSURES: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act, Section 164.500 et. seq.

SPECIAL CIRCUMSTANCES: Alcohol and drug abuse and certain infectious disease information have special privacy protections. The Practice will not disclose any information identifying an individual as being a patient or provide any health information relating to the patient's substance abuse or certain infectious disease treatment unless the patient authorizes in writing; to carry out treatment, payment, and operations; or, as required by law.

FUNDRAISING/MARKETING: The Practice will not use your protected health information for fundraising or marketing purposes or sell your protected health information without your written permission.

2. Your Rights
Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights. The following uses and disclosures will only be made with your written authorization: (i) most uses and disclosures of psychotherapy notes;(ii) Other than face-to-face conversations about services and treatment alternatives we will not use your protected information for third party marketing purposes without your authorization; (iii) disclosures that constitute a sale of PHI; (iv) other uses and disclosures not de- scribed in the Notice of Privacy Practices.

You have the right to request a restriction or a limitation on the medical information we use or disclose about your treatment, payment or health care operations. You have the right to restrict disclosure of PHI to a health plan where you paid out-of-pocket, in full, for the care or service provided.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about your health care. The request must be made in writing to Medical Clinic of North Texas. If you request a copy of your medical record, the Practice will provide you a copy within 30 days. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

Right to Access and Notice of Electronic Health Records under Texas Law. You are hereby notified that the Practice maintains an electronic health record system for your records. You may submit a written request to the Practice for a copy of your electronic health records which will be provided to you electronically within 15 days unless you agree to accept your records in another form. Under limited circumstances, your request may be denied.

You are hereby notified that your electronic health record is subject to electronic disclosure. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.

Your request must state the specific restriction requested and to whom you want the restriction to apply. You have the right to restrict disclosure of PHI to a health plan where you paid out-of-pocket, in full, for the care or service provided. We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If we do agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with the Practice Physician's manager. You may request a restriction by submitting your written request to the manager of the Practice.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer at 2245 Brinker Rd, Denton, TX 76208.

You may have the right to have your physician amend your protected health information.
This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information for the purpose of correcting an error or misinformation. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and that statement will become part of your medical record. Your physician may prepare a rebuttal to your statement which will also become part of your medical record. Your physician will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes to legal or regulatory agencies. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

2. Questions or Complaints

If you have a question or complaint about your privacy rights, please contact the PE Privacy Officer via phone at 940-488-4767 or via mail at info@endont.com. Should the Privacy Officer be unable to resolve your complaint to your satisfaction, you may send a written complaint to the Office of Civil Rights, U.S. Department of Health & Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201. We will not retaliate against you for filing a complaint.

Form-Acknowledgement, PRECISION ENDOCRINOLOGY, PLLC

ACKNOWLEDGMENT OF PRIVACY PRACTICES/FINANCIAL DISCLOSURE I understand that I have the right to restrict how my Health Information (defined below) is used or disclosed by PRECISION ENDOCRINOLOGY, PLLC and its affiliated companies (hereinafter collectively referred to as "PE") to carry out treatment, payment, or health care operations. I may seek to restrict these uses or disclosures by designating my restrictions in writing, however, I understand that PE is authorized by federal law to refuse to abide by my requested restrictions and that restrictions on use of Health Information for payment, treatment, or health care operations may prevent me from receiving medical Services at PE. RELEASE OF INFORMATION: I consent and authorize PE and any practitioner providing medical goods and services to patient to release information contained in any financial records and/or medical records, including diagnosis and treatment at PE or by any practitioner providing medical goods and services to the patient, including but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), Hepatitis A, B and C, drug/alcohol abuse and treatment, psychiatric diagnosis and treatment records and/or laboratory tests results, medical history, treatment progress, and/or other such related information (collectively "Health Information") for the purpose of payment, treatment, or health care operations to one or more of the following:

1. Insurance Company, self-funded or health plan, its agents, representatives, attorneys or independent contractors, Medicare Medicaid, any other person or entity that may be responsible for paying or processing for payment any portion of my PE bill or conducting utilization management/review and financial/medical audits;
2. To any person or entity affiliated with or representing PE and any practitioner providing medical goods and services to patients for the purpose of payment, treatment and health care operations;
3. To any other hospital, nursing home, or other health care institution to which the patient is transferred;
4. Patient's primary, attending, consulting, referring, and/or family physician for follow up, physician information and/or continuity of care to include prospective or current home health company, to referring facility health care staff or to PE.

In addition, I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy Notice, a copy of which has been provided to me. I have read or will read the Privacy Notice and ask PE if I have any questions about the information contained in the Privacy Notice. I agree to the uses/disclosure of my/my child's Health Information as described in the Privacy Notice. Moreover, I understand that the Privacy Notice may be amended by PE from time to time and that I may obtain an amended Privacy Notice at any time by contacting PE' registration/front office personnel or by obtaining an updated version at www.endont.com. I give permission for the release of Health Information to be transmitted by U.S. Mail, facsimile or other electronic medium. I may revoke this Consent to Release Health Information in writing at any time, unless action has already been taken in reliance thereupon; in which case, I may revoke this Consent for future communications. I give my permission to PE and its agents, employees and representatives to use the contact information, including cell phone numbers, I have provided to contact me for payment, treatment or any other health care purposes.

MEDICARE/TRICARE PATIENTS ONLY: I acknowledge receipt of the written material entitled "Important Message for Medicare/Tricare." FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS AND RIGHTS: I hereby irrevocably assign, transfer and convey to PE and any practitioner providing care and treatment to me/my child, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee welfare benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I receive from PE. If my/my child's treatment was caused by events which result in legal action, I assign to PE an interest in any claims I/my child may have arising from or in connection with the delivery services by PE to me/my child. I hereby promise to pay for all of the services rendered to me/my child to the extent I am legally responsible for such payment. I understand I am responsible for all health insurance co-payments and deductibles and any other amounts properly payable by me as permitted by law or contract. Charity care may be available if PE eligibility criteria are met. DESIGNATION OF AUTHORIZED REPRESENTATIVE: I designate and appoint PE (and its agents) as my authorized representative and authorize it to act on my behalf to (1) request and receive a copy of the summary plan description: (2) pursue a benefit claim; (3) appeal an adverse benefit determination; and/or (4) file a legal/equitable action to recover benefits from my employee welfare benefit plan, insurance policy, any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child at PE, any requests for documents relating to this claim and appeal of an adverse determination of the claim. This document shall remain in force until a written revocation by me is delivered to PE. MEDICAID PATIENTS ONLY: I understand that the amount owed to PE for covered services will be satisfied by amounts paid by Medicaid for such services and that I will not be balance billed by PE for Medicaid covered services. I further understand that the services or items that I request to be provided to me may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my/my child's care. I understand that the Texas Health and Human Services Commission or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my/my child's care. If I am a Medicaid STAR patient, I acknowledge that some of these provisions may not apply. I hereby certify and affirm that I have the legal authority to make the above assignment of benefits and designation of authorized representative and, if other than a parent of the child receiving treatment, will provide upon request appropriate legal documentation of such authority (e.g., legal guardianship, power of attorney, court order).

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION
AND RECEIVED A COPY OF THE PE NOTICE OF PRIVACY PRACTICES.

Patient's Name Printed: _____ Date of Birth: _____

_____
Signature of Patient, if adult, or Patient's Parent/Legally Authorized Representative Relationship

Witness:_____

Time of Signing: Month _____ Day _____ Year _____ Hour _____ a.m./p.m.