SPECIALTY INFUSION CENTERS

PATIENT REGISTRATION FORM

Patient's Name (Last, First, MI): _____

Primary Phone Number: _____ Alternate Phone Number: _____

E-Mail Address: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: M / F Social Security Number: _____

Emergency Contact: _____ Relationship to Patient: _____

Phone Number: _____ **How did you hear about us?** ☐ Google ☐ Doctor ☐ Family/Friend ☐ Social Media

INSURED INFORMATION (IF OTHER THAN PATIENT)

We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _____ Social Security Number: _____

Relationship to Patient: _____ Date of Birth: _____

Primary Policy: _____ Member ID: _____

Secondary Policy: _____ Member ID: _____

GUARANTOR INFORMATION

Guarantor First Name: _____ Guarantor Last Name: _____

Social Security Number: _____ Date of Birth: _____

Relationship to Patient: _____ Phone Number: _____

Address: _____

MEDICAL HISTORY

Do you have any allergies? If so, please explain _____

When was the date of your last infusion? _____

Do you have a history of hypertension? If so, please explain _____

If yes, have you seen your PCP in the last 6 months? _____

Are you currently taking any medication? If so, please explain _____

Patient / Parent or Guardian Signature: _____ Date: _____

PATIENT CONSENT

1. CONSENT TO INFUSION THERAPY, MEDICAL CARE AND TREATMENT

I voluntarily consent to any and all health care treatment and diagnostic procedures, including but not limited to infusion therapy, medical examinations, and tests, provided by _____ (the "Infusion Center") and its associated physicians, providers, nurses, and clinicians (collectively, the "Clinicians"). I understand that in many instances the Clinicians are carrying out orders from my referring health care provider. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my referring provider's or the Clinicians' recommendations as they may relate to my health that the Infusion Center and the Clinicians will not be responsible for any injuries or damages that are the result of my non-compliance. I understand that if any employee or any individual associated with the Infusion Center is exposed to my blood or body fluids, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to the exposure.

2. CONSENT TO TREATMENT IN AN OPEN TREATMENT AREA

I acknowledge and understand that the Infusion Center provides infusion therapy and medical care in an open treatment environment. Despite safeguards and using reasonable care, it is always possible in the Infusion Center that I may learn information regarding other patients or they may inadvertently learn something about me. In all cases, the Infusion Center expects and requires that its patients maintain strict confidentiality of any inadvertently disclosed health information of others.

3. CONSENT TO USE OF INFORMATION

Electronic Health Records. I understand that the Infusion Center may collaborate with other health care providers to coordinate, manage, and provide health care to me, and I voluntarily consent to the Infusion Center's sharing my health information and records electronically or otherwise for the purposes of treatment, payment, and operations and other purposes as outlined in the Infusion Center's Notice of Privacy Practices. I consent to the inclusion in my electronic health record of any sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. I understand that my electronic health records will be accessible by our Clinicians and other Infusion Center personnel and individuals approved to access such records for purposes related to treatment, payment, and health care operations and other purposes as outlined in the Infusion Center's Notice of Privacy Practices.

Use and Disclosure of Information. In addition, I acknowledge and agree that the Infusion Center may use and disclose my health information for a range of purposes, including but not limited to: treatment, eligibility verification, and payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Workers' Compensation programs, quality of careassessment and improvement activities, evaluating the performance of qualifications of Clinicians, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory, and accreditation requirements, and public health and health oversight services. All of these uses and disclosures are more fully outlined in the Infusion Center's Notice of Privacy Practices.

Request for Information from Others. I consent to Infusion Center's request of my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above, and Infusion Center's participation in any health information exchange described in the Infusion Center's Notice of Privacy Practices

4. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of the Infusion Center's Notice of Privacy Practices, which provides information on how the Infusion Center may use or disclose my health information.

5. ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to the Infusion Center for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.

6. FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products (e.g. medications) provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid, or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered products and non-covered services also may include those products and services the Infusion Center and the Clinicians initially determine to be medically necessary but are later determined unnecessary or denied by my insurance or payer.

7. PERSONAL VALUABLES

I understand that the Infusion Center does not accept responsibility for any lost, stolen, or damaged personal items while I am at the Infusion Center.

Patient Name: _____ Patient Date of Birth: _____

Street Address: _____

City: _____ Zip: _____

_____ _____

Patient Signature or Legal Representative Signature Today's Date:

If Signed by Legal Representative, Relationship to Patient (e.g. parent, spouse, etc:

_____

(Print Name and Provide Relationship)

SPECIALTY INFUSION CENTERS

PATIENT FINANCIAL AGREEMENT & ASSIGNMENT OF BENEFITS

1. DISCLOSURE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS: I authorize NYC Medical Infusion to share my medical information and medical records to my insurance company and third party-payers. I also assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to my insurance company for payment.

I assign any benefits to NYC Medical Infusion that I may have for reimbursement for my medical treatment received by NYC Medical Infusion which I may be entitled to from any insurance coverage, worker's compensation benefits, disability benefits, and all settlements, judgments, and verdicts against any liable third party.

All patients must provide to NYC Medical Infusion accurate and complete personal information as well as accurate and complete insurance information prior to being seen by the physician, physician's assistant, nurse, or other medical care provider/practitioner. We reserve the right to contact you annually to verify and/or update the personal and insurance information that we have on file for you. However, it is your sole responsibility to contact NYC Medical Infusion and advise us if and when any of your personal and/or insurance information changes.

2. ALL PAYMENTS DUE AT TIME OF SERVICE: While NYC Medical Infusion as a courtesy to patients will bill most insurance companies; NYC Medical Infusion is under no obligation do so. If your insurance company fails to pay all or part of your bill, you are responsible for all charges. By signing this agreement, I agree to accept full responsibility for all NYC Medical Infusion charges. Full payment is required at the time of service and may be in the form of cash or credit/debit card; checks are not accepted. If you are paying by credit/debit card, please be advised that NYC Medical Infusion accepts Visa, MasterCard, Discover and American Express.

3. UNDERSTANDING YOUR MEDICAL BENEFITS: We will be glad to file a claim on your behalf with your insurance provider. It is your responsibility to comply with any and all pre-determined, pre-authorization, and/or notification requirements as may be required by your insurance provider. Many of the services provided by NYC Medical Infusion may be covered benefits under your insurance plan. However, how these benefits are paid by your insurance provider and/or whether or not certain services are considered to be non-covered services is determined strictly by your insurance provider and not by NYC Medical Infusion. It is your personal responsibility to understand the limitations and exclusions of your insurance plan, as well as to understand your co-pays, deductible, and in-network and out-of-network portions including any and all applicable limitations, inclusions and/or exclusions.

4. THE RESPONSIBLE PARTY: In all cases and situations, NYC Medical Infusion requires that the guarantor/responsible party (the personal who is financially responsible) is the person who is personally financially responsible and liable for any and all balances due or that may become due which stem from today's visit. Should NYC Medical Infusion find it necessary to forward an account balance to a collection agent and/or agency, the guarantor/responsible party is and will be the party financiallv responsible for any and all charges incurred by said agent and/or agency.

5. ADDITIONAL FEES: NYC Medical Infusion may charge reasonable fees for services related to your account, including but not limited to, returned check fees, non-sufficient funds (NSF), interest on unpaid accounts and copies of medical records.

6. MEDICAL REPORTING: Federal law requires that we submit every claim to an insurance company accurately and report the exact services performed as well as the exact reason for performing those services. As such, please be advised that NYC Medical Infusion will not alter, in any way, any information related to your visit as a means to secure payment from your insurance provider that is over and above the scope of your insurance plan.

SPECIALTY INFUSION CENTERS

PATIENT FINANCIAL AGREEMENT & ASSIGNMENT OF BENEFITS

Signature of Patient or Legal Guardian _____ Date: _____

Relationship to Patient _____ Witness _____

I hereby give permission to my physician & office personnel to verbally discuss any and all of my medical condition(s) with the following person(s).

_____ Print Individual Name & Phone #

_____ Print Individual Name & Phone #

_____ Print Individual Name & Phone #

_____ Print Individual Name & Phone #

I DO NOT GRANT PERMISSION to my physician & office personnel to verbally discuss any and all of my medical condition(s) with the following person(s).

_____ Print Individual Name & Phone #

If you have any questions about this notice or any complaints about privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact:

Jason Deutsch
Clinical Director
NYC Medical Infusion, PC
1047 Surf Avenue
Brooklyn, New York 11224
(212) 776-9090

This notice went into effect November 1, 2014.
I ACKNOWLEDGE THAT I HAVE READ, UNDERSTOOD, AND RECEIVED A COPY OF THIS NOTICE.

Patient's Signature: _____ Date: _____

If under 18, Patient Guardian's Signature: _____ Date: _____

HIPAA PRIVACY NOTICE

YOUR INFORMATION • YOUR RIGHTS • OUR RESPONSIBILITIES

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.

As part of the federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA, NYC Medical Infusion has created this Notice of Privacy Practice ("Notice'). This Notice states NYC Medical Infusion's privacy practices and the rights you, the individual, have as they relate to the privacy of your Protected Health Information ("PHI"). Your PHI is information about you, or that could be used to identify you, as it relates to your past and present physical and mental health care services. We, at NYC Medical Infusion want you to know that nothing is more central to our operations than maintaining the privacy of your PHI. We take our responsibility to protect this information very seriously. The HIPAA regulations require that NYC Medical Infusion, and our Business Associates and their subcontractors, protect the privacy of your PHI that we have received or created. For any uses or disclosures that are not listed below (Including Marketing and Selling of PHI), NYC Medical Infusion will obtain a written authorization from you for that use of disclosures, which you will have the right to revoke at any time, as explained in more detail below. NYC Medical Infusion reserves the right to change our privacy practices and this Notice. If you have questions about this Notice, please contact the Privacy Officer referenced in the Contact Information at the end of the Notice.

NYC Medical Infusion will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization, others will not. Below you will find the different categories of uses and disclosures.

A. USES AND DISCLOSURES RELATED TO TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

A healthcare provider may use and disclose your PHI without your consent for the following reasons:

A. For treatment. A healthcare provider may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care.

B. For health care operations. A healthcare provider may disclose your PHI to facilitate the efficient and correct operation of their practice. A healthcare provider may also provide your PHI to their attorneys, accountants, consultants, and others to make sure that they are in compliance with applicable laws.

C. To obtain payment for treatment. A healthcare provider may use and disclose your PHI to bill and collect payment for the treatment and services provided to you.

D. During an emergency. Your consent isn't required if you need emergency treatment provided that a healthcare provider attempts to get your consent after treatment is rendered. In the event that a healthcare provider tries to get your consent but you are unable to communicate with them, e.g., you are unconscious or in severe pain, but they think that you would consent to such treatment if you could, they may disclose your PHI.

B. CERTAIN OTHER USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR CONSENT

NYC Medical Infusion may also use and disclose your PHI without your consent for the following reasons:

HIPAA PRIVACY NOTICE

YOUR INFORMATION • YOUR RIGHTS • OUR RESPONSIBILITIES

A. USES AND DISCLOSURES AS REQUIRED BY LAW: We must disclose your PHI when required to do so by applicable federal or state law.

B. USES AND DISCLOSURE FOR PUBLIC HEALTH ACTIVITIES: We may disclose your PHI to federal, state, or local authorities, or other entities charged with preventing or controlling disease, injury, or disability for public health activities. These activities may include the following: disclosures to report reactions to medications or other products to the U.S. Food and Drug Administration or other authorized entity; disclosures to notify individuals of recalls, exposure to a disease, or risk for contracting or spreading a disease or conditions.

C. USES AND DISCLOSURE ABOUT VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE: NYC Medical Infusion may use or disclose PHI about you to a government authority if it is reasonably believed you are a victim of abuse neglect or domestic violence.

D. USES AND DISCLOSURES FOR HEALTH OVERSIGHT ACTIVITIES: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, and inspections, as necessary for our licensure and for government monitoring of the health care system, government programs, and compliance with federal and applicable state law.

E. DISCLOSURES TO INDIVIDUALS INVOLVED IN YOUR CARE: NYC Medical Infusion may disclose PHI about you to individuals involved in your care.

F. DISCLOSURES FOR JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: NYC Medical Infusion may disclose PHI about you in the course of any judicial or administrative proceedings, provided that proper documentation is presented to NYC Medical Infusion.

G. DISCLOSURES FOR LAW ENFORCEMENT PURPOSES: NYC Medical Infusion may disclose PHI about you to law enforcement officials for authorized purposes as required by law or in response to a court order or subpoena.

H. USES AND DISCLOSURES ABOUT THE DECEASED: NYC Medical Infusion may disclose PHI about a deceased, or prior to, and in reasonable anticipation of an individual's death, to coroners, medical examiners, and funeral directors.

I. USES AND DISCLOSURES FOR RESEARCH PURPOSES: NYC Medical Infusion may use and disclose PHI about you for research purposes with a valid waiver of authorization approved by an institutional review board or a privacy board. Otherwise, NYC Medical Infusion will request a signed authorization by the individual for all other research purposes.

J. USES AND DISCLOSURES TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: NYC Medical Infusion may use or disclose PHI about you, if it believed in a good faith, and is consistent with any applicable law and standards of ethical conduct, to avert a serious threat to health or safety.

K. USES AND DISCLOSURES FOR SPECIALIZED GOVERNMENT FUNCTIONS: NYC Medical Infusion may use or disclose PHI about you for specialized government functions including; military and veteran's activities, national security and intelligence, protective services, department of state functions, and correctional institutions and law enforcement custodial situations.

I. DISCLOSURE FOR WORKERS' COMPENSATION: NYC Medical Infusion may disclose PHI about you as authorized by and to the extent necessary to comply with workers' compensation laws or programs established by law.

M. DISCLOSURES FOR DISASTER RELIEF PURPOSES: NYC Medical Infusion may disclose PHI about you as authorized by law to a public or private entity to assist in disaster relief efforts and for family and personal representative notification.

N. DISCLOSURES TO BUSINESS ASSOCIATES: NYC Medical Infusion may disclose PHI about you to NYC Medical Infusion's business associates for services that they may provide to or for NYC Medical Infusion. To ensure the privacy of your PHI, we require all business associates to apply appropriate safeguards to any PHI they receive or create.

O. DISCLOSURE AFTER DEATH: NYC Medical Infusion may disclose deceased individuals' PHI to non-family members, as well as family members, who were involved in the care or payment for healthcare of the decedent prior to death; however, the disclosure must be limited to PHI relevant to such care or payment and cannot be inconsistent with any prior expressed preference of the deceased individual.

D. APPOINTMENT REMINDERS AND HEALTH RELATED BENEFITS OR SERVICES: NYC Medical Infusion is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or health-related benefits and services that may be of interest to you.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

1. THE RIGHT TO VIEW AND OBTAIN COPIES OF YOUR PHI. You have a right to see, and to keep a copy of, all of your health records except psychotherapy notes and information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. Your request for a copy of your record must be in writing. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee. In very limited circumstances your request to inspect and obtain a copy of your health information may be denied. In that case, you may request that the denial be reviewed by an independent person.

2. THE RIGHT TO REQUEST LIMITS ON USES AND DISCLOSURES OF YOUR PHI. You can ask us not to use or share certain health information for treatment, payment, or our 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. Additionally, you may obtain restrictions on the disclosure of your PHI to a health plan for payment or healthcare operations with respect to specific items and services for which you have paid out of pocket in full. To request a restriction, you must make your request in writing using the Contact Information at the end of this Notice. In your request, you must indicate (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosures to your spouse or parent). We are not required to agree to your request, and we may say "no" if it would affect your care.

3. THE RIGHT TO CHOOSE HOW A HEALTHCARE PROVIDER SENDS YOUR PHI TO YOU. It is your right to ask that your PHI be sent to you at an alternate address or by an alternate method. The healthcare provider is obliged to agree to your request providing that they can give you the PHI in the format you requested, without undue inconvenience.

4. YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES. You have the right to request a list of disclosures of your health information that we have made that were not for treatment, payment, or health care operations, required by law, or authorized by you. Your written request must state the time period for the requested information and be no greater than six years prior to date of request. The healthcare provider will respond to your request for an accounting of disclosures within 60 days of receiving your request.

5. THE RIGHT TO AMEND YOUR PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that the healthcare provider corrects the existing information or adds the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of receipt of your request. If your request is denied, you have the right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and the denial be attached to any future disclosures of your PHI.

6. THE RIGHT TO RECEIVE ADDITIONAL COPIES OF THIS HIPAA PRIVACY NOTICE. You have the right to request an additional paper or electronic copy of this notice. You also have the right to direct the healthcare provider to transmit an electronic copy of PHI to an entity or person designated by you.

7. NOTIFICATION OF BREACHES. You will be notified of any breaches that have compromised the privacy of your PHI.

ADDITIONAL HIPAA RULES AND INFORMATION

A. MINIMUM NECESSARY RULE: Our staff will not use or access your PHI unless it is necessary to do their jobs (i.e. doctors uninvolved in your care will not access your PHI; ancillary clinical staff caring for you will not access your billing information; billing staff will not access your PHI except as needed to complete the claim form for the latest visit; janitorial staff will not access your PHI). All of our team members are trained in HIPAA Privacy rules and sign strict Confidentiality Contracts with regards to protecting and keeping private your PHI. So do our Business Associates and their Subcontractors. Know that your PHI is protected several layers deep with regards to our business relations.

B. INCIDENTAL DISCLOSURE RULE: We will take reasonable administrative, technical and security safeguards to ensure the privacy of your PHI when we use or disclose it. However, in the event that there is a breach in protecting your PHI we will follow Federal Guidelines to HIPAA Omnibus Rule Standard to first evaluate the breach situation using the Omnibus Rule, 4-Factor Formula for Breach Assessment. Then we will document the situation, retain copies of the situation on file, and report all breaches (other than low probability as prescribed by the Omnibus Rule) to the US Department of Health and Human Services at:

https://www.hhs.gov/hipaa/for-professionals/breach-notification/breach-reporting/index.html

We will also make proper notification to you and any other parties of significance as required by HIPAA Law.

C. BUSINESS ASSOCIATE RULE: Business Associates and other third parties (if any) that receive your PHI from us will be prohibited from re-disclosing it unless required to do so by law or you give prior express written consent to the re-disclosure. Nothing in our Business Associates agreement will allow our Business Associates to violate this re-disclosure prohibition, Under Omnibus Rule, Business Associates will sign a strict confidentiality agreement binding them to keep your PHI protected and report any compromise of such information to us, you and the United States Department of Health and Human Services, as well as other required entities. Our Business Associates will also follow Omnibus Rule and have any of their Subcontractors that may directly or indirectly have contract with your PHI, sign Confidentiality Agreements to Federal Omnibus Standard.

D. SUPER-CONFIDENTIAL INFORMATION RULE: If we have PHI about you regarding communicable diseases, disease testing, alcohol or substance abuse diagnosis and treatment, or psychotherapy and mental health records (super confidential information under the law)we will not disclose it under the "USES AND DISCLOSURES RELATED TO TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS" Rules above without your first signing and properly completing our Authorization form (i.e. your specifically must initial the type of super-confidential information we are allowed to disclose). If you do not specifically authorize disclosure by initialing the super-confidential information, we will not disclose it unless authorized under the Special HIPAA Disclosure Rules (i.e. we are required by law to disclose it). If we disclose super confidential information (either because you have initialed the consent form or the Special Rules authorizing us to do so), we will comply with state and federal law that requires us to warn recipient in writing that re-disclosure in prohibited.

E. FAXING AND EMAILING RULE: When you request us to fax or email your PHI as an alternative communication, we may agree to do so, but only after having our Privacy Officer or treating doctor review that request. For this communication, our Privacy Office will confirm that the fax number or email address is correct before sending the message and ensure that the intended recipient has sole access to the fax machine or computer before sending the message; confirm receipt, locate our fax machine or computer in a secure location so unauthorized access and viewing is prevented; use a fax cover sheet so the PHI is not the first page to print out (because unauthorized persons may view the top page); and attach an appropriate notice to the message. Our emails are all encrypted per Federal Standard for your protection.

F. PRACTICE TRANSITION RULE: If we sell our practice, our patient records (including but not limited to your PHI) may be disclosed and physical custody may be transferred to the purchasing healthcare provider, but only in accordance with the law. The healthcare provider who is the new records owner will be solely responsible for ensuring privacy of your PHI after the transfer and you agree that we will have no responsibility for (or duty associated with) transferred records. If all the owners of your practice die, our patient records (including but not limited to your PHI) must be transferred to another healthcare provider within 90 days to complv with State & Federal Laws. Before we transfer records in either of these two situations, our Privacy Officer will obtain a Business Associate Agreement from the purchaser and review your PHI for super-confidential information (i.e. communicable disease records), which will not be transferred without your express written authorization (indicated by your initials on our Consent form).

G. INACTIVE PATIENT RECORDS: We will retain your records for seven years from your last treatment or examination, at which point you will become an inactive patient in our practice and we may destroy your records at that time (but records of inactive minor patients will not be destroyed before the child's eighteenth birthdav). We will do so only in accordance with the law (i.e. in a confidential manner, with a Business Associate Agreement prohibiting re-disclosure if necessary).

H. COLLECTIONS: If we use or disclose your PHI for collections purposes, we will do so only in accordance with the law.

COMPLAINTS

If you believe NYC Medical Infusion has violated your privacy rights, or if you object to a decision that was made about access to our PHI, vou are entitled to file a complaint with the Privacy Officer listed below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at, 200 Independence Avenue S.W., Washington, D.C., 20201.

If you file a complaint about privacy practices, NYC Medical Infusion, PC will take no retaliatory action against you.

Person to contact for information about this notice or to complain about privacy practices.

Jason Deutsch
Clinical Director
NYC Medical Infusion, PC
1047 Surf Avenue
Brooklyn, New York 11224
(212) 776-9090