EKO INTERNAL MEDICINE

ARNOLD EKO-ISENALUMHE, M.D.

WINCHESTER OFFICE
2204 COWAN HIGHWAY
WINCHESTER, TN 37398
PHONE: (931) 967-0360
FAX: (931) 967-0810

MONTEAGLE OFFICE
25 SPRING STREET
MONTEAGLE, TN 37356
PHONE: (931) 924-2120
FAX: (931) 924-2069

PATIENT INFORMATION

ACCT _____

PLEASE PRINT CLEARLY. IF INFORMATION BELOW IS INCOMPLETE OR INVALID, YOU MAY BE RESPONSIBLE FOR FULL PAYMENT OF SERVICES. THANK YOU.

Last Name_____ First Name _____ MI _____

Date of Birth _____ Sex: M F SS# _____

Address: _____ Marital Status: M S W

City _____ State _____ Zip _____ Student: ____Yes ____No

Home Phone _____ Work Phone _____ Employed: FT PT RET DIS

Cell Phone _____ Emergency Phone _____

Emergency Contact: _____ Relationship _____

Referring Doctor Name _____ Why? _____

INSURANCE INFORMATION:

Do you have medical insurance ____ No ____Yes*

IF YES, YOU WILL NEED TO PRESENT YOUR CARD TO THE RECEPTIONIST AT EACH VISIT, AND FILL OUT THE INFORMATION BELOW.

Primary plan name _____ Workman's Comp? ____Yes ____No

Group #_____ ID# _____

If the patient the policy holder? ____ Yes ____No* *If no, fill in below:

Policyholder name _____ Relationship to patient _____

Policyholder SSN _____ Date of birth _____

Employer Name _____ Phone _____

Group#_____ ID# _____

Policy Holder Name _____ Date of Birth _____

If person responsible for payment of balance is different from patient or policyholder, please fill out below:

Responsible party name _____ Relationship _____

Address _____ Phone _____

City _____ State _____ Zip _____

I authorize the release of information to insurance necessary for payment of claims and benefits assigned to provider

_____ _____

Patient/responsible party signature Date

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NAME

AUTHORIZATION FOR MEDICAL TREATMENT

I authorize Dr._____ and his/her physician extenders to conduct and direct my medical care while I am a patient at Eko Internal Medicine. I also authorize Eko Internal Medicine staff, directed by my physician, to give medications, perform diagnostic procedures and provide other care which, in the judgement of my doctor, is required for my best care and treatment.

ASSIGNMENT OF BENEFITS

I direct and authorize payment directly to my physician for all monetary benefits available to me. It is expressly understood and agreed that acceptance of the said hospital, of benefits under this policy, shall in no way operate to release the person responsible for payment of the services referred to herein from his/her obligation to pay for all charges not covered by my insurance policy or in excess of said policy limits.

GUARANTEE OF PAYMENT

For value received, the undersigned hereby unconditionally guarantees the prompt payment of all its charges, hereby agreeing to pay all costs and expenses incurred in enforcing this guarantee.

In the event the patient or guarantor fails to comply with their obligation herein, each consents to the disclosure of their identify and any other necessary information relating to the service rendered to the patient by the attending physician to any collection agency or attorney at law, for the purpose of enforcing the patient's or guarantor's obligation to the health group and the re-disclosure of such information by the collection agency or attorney. Such disclosure or re-disclosure shall not be deemed to be a breach of the patient confidentiality by the health group.

RELEASE OF WRITTEN AND/OR VERBAL INFORMATION FOR BILLING AND UTILIZATION REVIEW PROCESS

I authorize my physician to release written and/or verbal information from my medical record, as necessary, to process my insurance claims and for utilization review when justification for treatment or continued treatment is required.
I have read the above statements or have had them read and explained to me.

X_____ _____

Patient Signature (Date)
Patient / Legal Guardian

_____ _____

Witness

MEDICARE ASSIGNMENT AND AGREEMENT TO PAY MEDICARE NON-COVERED CHARGES

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician to release to the Social Security Administration and/or its intermediaries and/or carriers any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician services to the physician or organization furnishing these services, or authorize the above to submit a claim to Medicare to payment to me. I understand Medicare Participating Physicians have been advised by the Health Care Financing Administration (HCFA) that services provided to Medicare Beneficiaries, which are determined by HCFA to be unnecessary, and will not be paid for my Medicare. The Physician may not collect for these services from the patient, unless prior notification has been given. I request that this authorization apply to the period from _____ to _____.

_____ _____

Beneficiary Representative Payee Signature Date

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I, _____, give my authorization to my physician/physician's staff to discuss any medical issues concerning me to:

Name

_____ My spouse _____

_____ My son / daughter / children _____

_____ My caregiver _____

_____ Other _____

I, _____, also give my physician/physician's staff permission to leave a message on my home answering machine or to any person answering my home phone.

I, _____, also give permission to my physician/physician's staff to contact me at my place of employment. If I am unable to be reached there, I give permission to my physician/physician's staff to leave a message for me to return their call.

If there is any medical information I do not want to be discussed or a message to be left at my home or at my place of employment, I will notify my physician/physician's staff of this in writing. If there is any change in information pertaining to this consent, I will also notify my physician/physician's staff of this in writing.

I, _____, also give permission to my physician/physician's staff to fax any information regarding me to another physician's office that may be covering for my physician/physician's staff, or a physician I may be referred to by my physician/physician's staff.

_____

Name & Date

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Patient Name: _____

Date of Birth: _____

SSN# _____

I understand that my health information is private and confidential. I understand that Eko Internal Medicine works in every way possible to preserve the confidentiality of my personal health information.

I understand that signing this document means that Eko Internal Medicine may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in the physician declining to provide care.

Eko Internal Medicine has a detailed document called the "Notice of Privacy Practice". It contains more information about the policies and practices used to protect their patients' privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Eko Internal Medicine may update this "Notice of Privacy Practices". If I ask, Eko Internal Medicine will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Eko Internal Medicine to restrict how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that Eko Internal Medicine does not have to agree with my request. If Eko Internal Medicine does agree to my request, I understand that Eko Internal Medicine would follow the agreed limits.

I understand that I have the right to cancel this consent in writing, at any time. If I do cancel this consent, I understand that Eko Internal Medicine may have already used or disclosed information about me and canceling this consent would not effect the information already used or disclosed.

If you would like to designate someone to receive your medical information (tests results, appointments, referrals etc.) please provide a name and phone number.

_____

_____

Signature of Patient or Parent/Legal Guardian

_____

Date

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NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW THIS INFORMATION CAREFULLY

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EFFECTIVE DATE
April 14, 2003

This Notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

How your health information may be used

We may use health information about you for your treatment purposes, to obtain payment, or for healthcare operations and other administrative purposes. Examples of each item mentioned above include:

Treatment: We may need to send your medical record information to a specialist or physician as part of referral for continuity of care.

Payment: We will use your health information and other identifying information for billing Medicare, Medicaid or other health insurance plans.

Operations or administrative purposes: We use your information when processing your medical records for completeness and to compare patient data to improve our treatment methods.

How your health information may be disclosed

As a healthcare provider, we are subject to certain requirements in which we have to disclose your health information. These disclosures are generally routine to all patients and are done without your specific authorization for several reasons.

- State and Federal laws require us to report cases of abuse, neglect, or other reasons requiring law enforcement,
- public health activities,
- health oversight agencies,
- judicial and administrative proceedings,
- death and funeral arrangements,
- special government functions including military and veteran requests
- to prevent serious threat to health or public safety.
- correctional institutions, and
- workers compensation.

We may also contact you after your current visit for future appointment reminders or to provide you with information regarding treatment alternatives or other health related services that may be of benefit to you. We will obtain your written authorization for any other disclosures beyond the reasons listed above. Remember, if you do authorize us to release your information, you always have the right to revoke that authorization later. We will be happy to honor that request except to the extent that we may have already acted.

What your rights are with regards to how your information can be used and disclosed

Access to your Health Information

In most cases, you have the right to look at or receive a copy of your health information. There may be a preparation fee associated with making the copies.

Accounting of Disclosures

You have the right to ask for a list of instances in which we have disclosed your information for reasons other than treatment payment and operations. We can provide you one list per year without charge, all additional requests in the same year will be subject to a nominal charge.

Amendment/Correction of Health Information

If you believe that the information we have about you is incorrect or if important information is missing, you have the right to request that we amend the existing information. There may be some reason that we cannot honor your request for which you submit a statement of disagreement.

Alternate/Confidential Communications

You can request that your health information be communicated to you at an alternate location or address from which you may have registered with, such as sending mail to an address other than your home.

Restrictions on Use/Disclosure of Your Health Information

You can request in writing that we not use or disclose your information for any reasons in this brochure or to persons involved in your care except when specifically authorized by you or when required by law, or in emergency circumstances. We are not legally required to accept them, but will try to honor any reasonable requests.

Our Legal Duty

We are required by law to protect the privacy of your information. We are providing this notice to you so that we can explain what our privacy practices are. We will follow the practices described in this notice or the current notice in effect.

We reserve the right to change our policies and notice of privacy practices at any time. If we should make a significant change in our policies, we will change this notice and post the new notice. You can also request a copy of our notice at any time.

Complaints

For more information about our privacy practices or to place a complaint or report a concern or conflict, call the number listed below:

Eko Internal Medicine Privacy Officer (931) 598-5622

You may also send a written complaint to the United States Department of Health and Human Services, if you feel we have not properly handled your complaint. You can use the contact listed above to provide you with the appropriate DHHS address. Under no circumstance will you be retaliated against for filing a complaint. This notice applies to the physician practices affiliated with the Eko Internal Medicine.

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TODAY'S DATE: _____
(This form is good for 1 year from above date).

TEMP: _____ BP: _____
HT: _____ P: _____
WT: _____ R: _____

PATIENT HISTORY AND PHYSICAL FORM

(For new patients and to be updated annually)

PATIENT'S NAME: _____ **AGE:** _____

CHIEF COMPLAINT: (Why you are here today) _____

HISTORY OF PRESENT ILLNESS:

- **Location** of pain/problem? _____
- **How long** have you had this problem? _____
- How did the problem **start**? _____
- How **often** do you have the pain? _____
- What makes it **worse**? _____
- What makes it **better**? _____
- What **associated problems** have you been having? _____
- What is the **severity** of your pain? Mark an **X** on the appropriate circle below:

(No Pain) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (Extreme Pain)

- What does the pain **feel** like? (throbbing, shooting, sharp, etc) _____

GENERAL MEDICAL INFORMATION:

My general health is: (Please check one) ☐ Excellent ☐ Very Good ☐ Good ☐ Fair

Who is your family doctor: _____ **Date of last visit:** _____

Are you pregnant or attempting to get pregnant: ☐ YES ☐ NO

List any medications you are currently taking including strength and how often taken:

NAME	*DOSAGE*	*HOW OFTEN*	*NAME*	*DOSAGE*	*HOW OFTEN*

Are you currently taking (or have you taken in the past) diet pills or herbal supplements? ☐ YES ☐ NO

If yes, write name of the pill/supplement and date last taken: _____

ALLERGIES:

List medications and/or foods that you are ALLERGIC to or have had a bad reaction to: _____

What kind of reaction did you have? _____

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PAST MEDICAL HISTORY:

Check any problem you have ever been treated for and indicate the year of treatment:

- ☐ Arthritis
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Brittle Bones
- ☐ Broken Bones
- ☐ Ruptured Disc
- ☐ Sciatica
- ☐ Spinal Curvature
- ☐ Diabetes
- ☐ Stomach Ulcers
- ☐ Hypertension
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Irregular Heartbeat
- ☐ Peripheral Vascular Disease
- ☐ Stroke
- ☐ Blood Clots
- ☐ Vericose Veins
- ☐ Kidney Disease
- ☐ Bladder Infection
- ☐ Sickel Cell Anemia
- ☐ Blood Transfusion
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Gall Stones
- ☐ HIV / AIDS
- ☐ Tuberculosis
- ☐ Polio
- ☐ Venereal Disease
- ☐ Asthma
- ☐ Emphysema
- ☐ Cancer
- ☐ Hereditary Defects
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Depression
- ☐ Drug Dependency
- ☐ Head Injury
- ☐ Convulsions
- ☐ Fainting Spells
- ☐ Insomnia
- ☐ Gout

SURGICAL/HOSPITALIZATION HISTORY:

PRIOR SURGERIES:

Type of Surgery	Date of Surgery

PRIOR NON-SURGICAL HOSPITALIZATIONS, MAJOR ILLNESSES OR INJURIES:

Reason for Admit	Date of Admit

SOCIAL HISTORY:

Occupation: _____ **Marital Status:** S M W Dv Sp

Are you working now? _____ **If no, when did you work last?** _____

Place of Birth: _____ **Grade of School Completed:** _____

I live in a: ☐ House ☐ Apartment ☐ Condominium ☐ Mobile Home ☐ Boat

My home is: ☐ Single-Level ☐ Multi-Level # of stairs to enter: _____ # of stairs inside: _____

I live: ☐ Alone ☐ w/Spouse ☐ w/Parents ☐ w/Children Other _____

Alcohol Consumption:

Type: ☐ Beer ☐ Wine ☐ Whiskey ☐ None

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

If you have quit, how long? _____

Tobacco Use:

Type: ☐ Cigarettes ☐ Pipe ☐ Chew ☐ None

How much used daily? _____

and for how long? _____

If you have quit, how long? _____

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FAMILY HISTORY:

Mother: Living: YES or NO Age: _____ Condition of health: _____

If deceased, cause of death and age at death: _____

Father: Living: YES or NO Age: _____ Condition of health: _____

If deceased, cause of death and age at death: _____

Have you or any member of your family every had? (Indicate relative by placing a letter next to problem):
F-(father), **M**-(mother), **GF**-(grandfather), **GM**-(grandmother), **B**-(brother), **S**-(sister), **C**-(child), **U**-(uncle), **A**-(aunt)

- ☐ CANCER
- ☐ HEART ATTACK
- ☐ ARTHRITIS
- ☐ KIDNEY PROBLEMS
- ☐ EMPHYSEMA
- ☐ HIV/AIDS
- ☐ LUNG PROBLEMS
- ☐ ULCERS
- ☐ HIGH BLOOD PRESSURE
- ☐ DIABETES
- ☐ SEIZURES
- ☐ HEPATITIS
- ☐ COPD
- ☐ OSTEOPOROSIS
- ☐ BACK INJURY
- ☐ DEPRESSION
- ☐ HEART DISEASE
- ☐ STROKE
- ☐ TUBERCULOSIS (TB)
- ☐ ASTHMA
- ☐ LUPUS
- ☐ REACTION TO ANESTHESIA
- ☐ STOMACH PROBLEMS
- ☐ SKIN BREAKDOWN

SYMPTOM / SYSTEMS REVIEW:

If you have ever experienced any of the following problems, please check the problem and write the year you experienced it right next to the checked item OR check **NO PROBLEMS.**

GENERAL HEALTH / CONSTITUTIONAL SYMPTOMS

- ☐ Fatigue
- ☐ Difficulty sleeping
- ☐ Unexplained bleeding
- ☐ Fever/chills
- ☐ Night sweats
- ☐ Recent weight change
- ☐ Other _____
- ☐ **NO PROBLEMS**

HEAD / FACE

- ☐ Headaches
- ☐ Lesions or scars
- ☐ Reduced facial strength
- ☐ Recent hair loss
- ☐ Masses
- ☐ Facial paralysis
- ☐ Scalp tenderness
- ☐ Other _____
- ☐ **NO PROBLEMS**

EYES

- ☐ Blurred or double vision
- ☐ Dryness
- ☐ Redness of the eyes
- ☐ Visual disturbances
- ☐ Wear glasses or contacts
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other _____
- ☐ **NO PROBLEMS**

EARS / NOSE / MOUTH / THROAT

- ☐ Earaches or drainage
- ☐ Bad breath or bad taste
- ☐ Bleeding gums
- ☐ Hearing loss
- ☐ Mouth sores/ulcers
- ☐ Frequent sore throat
- ☐ Ringing in the ears
- ☐ Difficulty swallowing
- ☐ Voice changes
- ☐ Sinus infections/problems
- ☐ Sinus tenderness
- ☐ Dryness of the mouth
- ☐ Nosebleeds
- ☐ Hayfever
- ☐ Dentures
- ☐ Other _____
- ☐ **NO PROBLEMS**

NECK

- ☐ Masses
- ☐ Tenderness
- ☐ Thyroid tenderness
- ☐ Vein distention
- ☐ Swollen glands in the neck
- ☐ Pain
- ☐ Other _____
- ☐ **NO PROBLEMS**

CHEST / BREAST

- ☐ Breast discharge
- ☐ Breast implants
- ☐ Breast lump
- ☐ Breast pain
- ☐ Other _____
- ☐ **NO PROBLEMS**

CARDIOVASCULAR

- ☐ Chest pain or pressure
- ☐ Blood clots
- ☐ Swelling of feet and/or ankles
- ☐ Fast or irregular heart beat
- ☐ Palpitations
- ☐ Swelling of the hands
- ☐ Heart trouble
- ☐ Leg cramps
- ☐ Poor circulation
- ☐ Other _____
- ☐ **NO PROBLEMS**

RESPIRATORY

- ☐ Wheezing
- ☐ Chronic or frequent coughs
- ☐ Cough with mucous production
- ☐ Difficulty breathing
- ☐ Dry cough
- ☐ Shortness of breath when lying flat
- ☐ Shortness of breath when walking
- ☐ Pain on breathing
- ☐ Spitting/coughing blood
- ☐ Other _____
- ☐ **NO PROBLEMS**

SYMPTOM / SYSTEMS REVIEW (continued):

If you have ever experienced any of the following problems, please check the problem and write the year you experienced it right next to the checked item OR check **NO PROBLEMS.**

GASTROINTESTINAL

- ☐ Heartburn or indigestion
- ☐ Changes in bowel movements
- ☐ Rectal bleeding or blood in stool
- ☐ Painful bowel movements
- ☐ Constipation
- ☐ Loss of appetite
- ☐ Nausea or vomiting
- ☐ Abdominal pain
- ☐ Frequent diarrhea
- ☐ Stomach pain or cramps
- ☐ Other _____
- ☐ **NO PROBLEMS**

GENITOURINARY

- ☐ Burning or painful urination
- ☐ Blood or pus in urine
- ☐ Vaginal discharge
- ☐ Incontinence or dribbling
- ☐ Pain with periods
- ☐ Sexual difficulty
- ☐ Genital rash or ulcers
- ☐ Irregular periods
- ☐ Testicular pain
- ☐ Change in force of strain when urinating
- ☐ Prostate problems
- ☐ Other _____
- ☐ **NO PROBLEMS**

LYMPHATIC / HEMATOLOGIC

- ☐ Bleeding or bruising tendency
- ☐ Enlarged glands
- ☐ Phlebitis
- ☐ Slow to heal after cuts
- ☐ Other _____
- ☐ **NO PROBLEMS**

MUSULOSKELETAL / EXTREMITIES

- ☐ Back pain
- ☐ Cold extremities
- ☐ Difficulty climbing stairs
- ☐ Difficulty walking
- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Numbness or tingling
- ☐ Paralysis
- ☐ Walk with a limp
- ☐ Walk with assistive device
- ☐ Walk only limited distances
- ☐ Weakness of muscles or joints
- ☐ Other _____
- ☐ **NO PROBLEMS OTHER THAN REASON FOR VISIT**

NEUROLOGICAL / PSYCHIATRIC

- ☐ Convulsions or seizures
- ☐ Frequent/recurring headaches
- ☐ Numbness or tingling sensation
- ☐ Tremors
- ☐ Memory loss or confusion
- ☐ Light headed
- ☐ Loss of consciousness
- ☐ Feeling blue
- ☐ Dizziness
- ☐ Other _____
- ☐ **NO PROBLEMS**

INTEGUMENTARY / SKIN

- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Psoriasis
- ☐ Rash or itching
- ☐ Skin nodules or bumps
- ☐ Skin changes after sun exposure
- ☐ Other _____
- ☐ **NO PROBLEMS**

PLEASE LIST OTHER PERTINENT INFORMATION YOUR PHYSICIAN SHOULD KNOW:

_____

_____

_____

_____

_____

_____

_____

I hereby attest that I personally completed this form and all the information is true and correct.

_____ _____

Signature of Patient or Guardian completing form **Date**

HISTORY FORM REVIEWED BY: _____ DATE: _____

PHYSICIAN'S OR PHYSICIAN ASSISTANT'S SIGNATURE

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PRESCRIPTION HISTORY CONSENT

I hereby give consent to DR. EKO-ISENALUMHE I.A, his employees or agents to obtain my prescription history from any pharmacy that has dispensed any medications to me for the purpose of establishing my treatment history.

I here authorize the below-named pharmacy to release and disclose my prescription history to DR. EKO-ISENALUMHE I.A, his employees and agents.

1. NAME OF PHARMACY _____

   ADDRESS: _____

   _____

   PHONE: _____

   FAX: _____

2. NAME OF PHARMACY _____

   ADDRESS: _____

   _____

   PHONE: _____

   FAX: _____

3. NAME OF PHARMACY _____

   ADDRESS: _____

   _____

   PHONE: _____

   FAX: _____

- I understand that I may revoke this consent at any time. Should I decide to revoke this consent, I must give written notice to Dr. EKO-ISENALUMHE.
- I understand that this consent does not limit the above-named health care provider, his employees or agents ability to use or disclose my information for treatment, payment, or health care operations or as otherwise permitted by law.
- I understand that a photocopy of this consent is to be considered as valid as the original.

PATIENT OR AUTHORIZED REPRESENTATIVE'S SIGNATURE _____

RELATIONSHIP TO PATIENT: _____ DATE _____

WITNESS: _____ DATE _____

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ADVANCE DIRECTIVES

I _____ certify that I do / do not have advance directive.

_____ _____ _____
Name Sign Date

In the event of an emergency, I do want to have full resuscitative measure. I have been advised of the risks and benefits.

_____ _____ _____
Name Sign Date

DNR ORDER
In the event that my heart stops, I do not wish to be resuscitated. I am signing this DO NOT RESUSCITATE order after discussion with my physician, Dr. Eko-Isenalumhe, and I understand the full implications.

_____ _____ _____
Name Sign Date

In the event that I can not make medical decisions I hereby appoint _____,

who is my _____ to make those decisions on my behalf.

_____ _____ _____
Name Sign Date

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Patient Portal Policy and Procedure

Eko Clinic provides the Patient Portal, in partnership with our electronic medical records vendor eClinicalWorks, as a free service to our patients who wish to view parts of their record. This has certain risks. In order to manage these risks, we need to impose some conditions of participation. By signing the Consent Form, you agree to these conditions.

How It Works:
A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons form viewing private information. This information is only accessible by the individual who knows the right password to log in to the portal site.

Protecting Your Private Health Information (PHI) and Risks:
This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two additional factors: the secure massage must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to access it. **We need you to make sure we have your correct email address and you MUST inform us if it ever changes.**

Keep track of who has access to your email account so that only you or someone you authorize can see messages you receive from us. If you think someone has learned your password, you should promptly go to the Portal and change it. Also, it is important to remember that all communication should be through the Portal, not your personal email, or they will not be secure.

It is our intent to offer the Patient Portal as a free service to our patients. We will provide adequate notice of any changes. We understand the importance of privacy in regards to your healthcare and PHI and will continue to strive to make all information as confidential as possible. We will keep all email lists secure and never purposefully share or release this information with any third party.

All data is stored at Eko Clinic and is HIPAA compliant. All new and established patients have signed a HIPAA agreement form.

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EKO INTERNAL MEDICINE

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You agree not to hold Eko Clinic or any of its staff liable for network infractions beyond its control.

Conditions of Participating in the Patient Portal:
Access to this secure Patient Portal is an optional service, and we reserve the right to suspend user access, modify services, or terminate it at any time. If we do suspend this service, we will notify you.

We need you to fully understand the stated conditions, and by signing the Consent Form, you agree to comply with them. If you do not understand, or do not agree to comply with our policies and procedures, please contact us to revoke your use of the Patient Portal.

Portal Use:
The patient Partal is intended to provide the following services:

- Review medical summary, visit history, medication list
- Update demographic information
- Review current and past statements

The Patient Portal is NOT intended to provide internet-based diagnostic medical services. Additionally, the following limitations apply:

- No Portal based triage and treatment requests. Diagnosis can only be made by and treatment rendered after the patient schedules and visits the provider.
- No emergent communications or services. In an emergency, it is always recommended to dial 911. If you or a dependent is SICK, please call our office to schedule an appointment.
- No requests for medication refills. Please call the office for all medication refills.

All communications via Patient Portal become part of your permanent patient record.

Response Time:
Once your account is enabled, you will receive a "welcome message" with details and log in information. Please log in to your Portal account within 48 hours of receiving the message. Again, note that you should never reply to messages through your private email inbox. We encourage you to use the Portal at any time.

Patient Acknowledgement and Agreement:
I acknowledge that I have read and fully understand Eko Clinic's Patient Portal Policy and Procedures. I understand the risks associated with online communication between myself and the practice and consent to the conditions outlined above. In addition, I acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care I receive at Eko Clinic. I agree to follow the instructions herein, as well as

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any other instructions that Eko Clinic may impose to communicate online. I have been proactive about asking questions and all of my questions have been answered with clarity. I understand and concur with all information herein.

_____

Patient Name

_____

Patient Signature

_____

Date

_____

Current Email Address