GLST GASTROINTESTINAL & LIVER SPECIALISTS OF TIDEWATER, PLLC

PATIENT INFORMATION

PCP Dr.: Referring Dr.: Acct. # **«PNumber»**

How did you hear about our practice?

Patient Last Name: «PLast» First Name: «PFirst» MI: «PInit»

Email:

Address: City: State: Zip Code:

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )

Preferred method of contact: □ Email □ Cell □ Home □ Work

Social Security Number: Date of Birth: Language:

Sex: (please check one) □ M □ F Race: Ethnicity:

Marital Status: (please check one) □ Married □ Single □ Divorced □ Widowed □ Other

Spouse's Name: SSN:

Spouse Date of Birth: Spouse Cell Phone: ( )

PHARMACY

Name: Phone Number: ( )

Address: City: State: Zip Code:

EMERGENCY CONTACT INFORMATION

Name: Relationship:

Home Phone: ( ) Work Phone: ( )

City: State:

INSURANCE INFORMATION: IT IS YOUR RESPONSIBILITY TO KNOW IF YOU NEED A REFERRAL.

Primary Insurance Name: Name of Insured:

ID Number: Relationship to Insured:

SS# of Insured: DOB of Insured:

Secondary Insurance Name:

ID Number: Group Number:

Name of Insured: Relationship to Insured:

SS# of Insured DOB of Insured:

Provide name and approximate dates if previously seen by another Gastroenterologist:

GASTROINTESTINAL & LIVER SPECIALISTS OF TIDEWATER, PLLC

AUTHORIZATION FOR TREATMENT & ASSIGNMENT OF BENEFITS

This will authorize the filing of any insurance in force for all charges, which include anesthesia and pathology, if applicable and the direct payment to Gastrointestinal & Liver Specialists of Tidewater, PLLC of any amount due on my claim under the above stated policy. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to Gastrointestinal & Liver Specialists of Tidewater, PLLC for non-payment of any fees not covered by insurance. I understand and agree to pay in full any balance due after an insurance payment or to make payment arrangements with Gastrointestinal & Liver Specialists of Tidewater, PLLC. In consideration of service rendered, the undersigned patient, spouse, and/or responsible party agrees to pay all cost of collections including attorney's and/or collection agency's fees in the range of 28 - 33-1/2% plus court cost and any interest allowable by law, if incurred. The practice at its discretion may apply a finance charge of 1.5% per month (18% APR) commencing 60 days from the date of service. I hereby authorize the release of any medical information necessary to process claim.

Patient Signature: ____ Date: __________

DEEMED CONSENT FORM

I understand that the laws of Virginia provide if my physician or any person employed by or under the direction and control of my physician(s) is directly exposed to my body fluids in any manner which may according to the then current guidelines for the Center of Disease Control transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my bodily fluids.

Patient Signature: ____ Date: __________

ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES/ CANCELLATION/ NO SHOW POLICY

1. _______(initial) I hereby acknowledge that I have had the opportunity to review a copy of the Notice of Privacy Practices. Please list anyone you are authorizing to have access to your medical records:

Name: __________________________Relationship: ________________DOB#: ________________

Name: __________________________Relationship: ________________DOB#: ________________

2. _______(initial) I hereby acknowledge that I understand there is a **$150.00** cancellation fee for procedures not canceled within **72 hours**, and a **$50.00** fee for office visits not canceled within **72 hours.**

ACKNOWLEGEMENT OF CONTINUOUS QUALITY IMPROVEMENT PROGRAM

Our organization participates with the Accreditation Association for Ambulatory Health Care (AAAHC) requirements for quality improvement. Due to these requirements, I acknowledge that there is a Continuous Quality Improvement program in place which requires patient medical records to be reviewed periodically. I agree to allow my medical record to be reviewed if it is selected as part of the program. I understand my information will be remain confidential and will not leave this facility.

Patient Signature: ____ Date: __________

Medical History Form

Today's Date: __________

«PName»	DOB: «PDOB»	ACCT. «PNumber»

Reason for your visit:	
Age	Gender □ Male □Female
Marital Status □Single □Married □Divorced □Widowed □Separated	Occupation
Primary Care Physicians Name :	
Have you been seen by another Gastroenterologist in the past 3 years? □ **YES** □**NO**	If yes. Who and when?
Are you allergic to any of the following?	□ Shellfish □Iodine □Dye □Latex □Tape
If yes to any please list your reaction (s)	
Allergies or "bad reactions" to medications or other substances? □ **YES** □ **NO**	If Yes, list the medications/substances and reactions.
Have you had problems with sedation medication or anesthesia? □ **YES** □ **NO**	

Medication History

Please list all Prescription and Non Prescription medications as well as herbal and dietary supplements you are currently taking. (Or you may attach a list)

Medication Name	Dosage	Times daily	Duration

Do you take any of the following medications even on an occasional basis?

□ *Coumadin* □ *Heparin* □ *Lovenox* □*Other Anticoagulants*

□ *Advil* □*Motrin* □*Ibuprofen* □*Other Pain Medication* □ *Aspirin* □ *Alka-Seltzer*

□ *Aspirin containing products*

«PName»	DOB: «PDOB»	ACCT. «PNumber»

Medical History

Have you or a close blood relative had any of the following:

Place a check in the box below

Condition	Self	Mother	Father	Sibling	Other	Explain
Asthma						
Breast Cancer						
Colon Cancer						
Colon Polyps						
Diabetes						
Esophageal Cancer						
Heart Disease or Failure						
High Blood Pressure						
Crohns, or Ulcerative Colitis						
Kidney Problems						
Liver Cancer						
Liver Disease						
Other Cancer						
Ovarian Cancer						
Pancreatic Cancer						
Sleep Apnea						
Stomach Cancer						
Stomach Ulcers						
Stroke						

Social History

Do you Use tobacco products? □**YES** □**NO** If former user year quit. ______	□Cigarettes □Pipe □Cigar □Smokeless Chew □ *less* than 1pk per day □ *More than* 1pk per day □ *More than* 2pks per day
Do you drink Alcohol? □ **YES** □ **NO**	□Wine □Beer □ Liquor □Daily □Weekly □Occasional
Do you use recreational or intravenous drugs? □**YES** □ **NO**	Have you used them in the past? □ **YES** □**NO**
Have you ever attended or felt you should attend a drug or alcohol rehabilitation program? □**YES** □ **NO**	If Yes Please Explain:
Do you have any Tattoos? □**YES** □ **NO**	What year (s) did you get them?_________
Have you ever had a blood transfusion? □ **YES** □**NO**	What Year? ________
Have you traveled in the past year? □ **YES** □ **NO** If yes, When? ________ Where? ___________	

«PName»	DOB:«PDOB»	ACCT. «PNumber»

Surgical, Hospitalization and Testing History

Please list any hospitalizations and surgeries you have had with the date, reason, and doctor.

Do you have a pacemaker or defibrillator? YES NO If yes when was it placed? __________________

Condition or Surgery	***Date: Month and Year***	***Physician***
Females: last menstrual period	***Month Year***	

Have you had any of the following testing/immunizations?

Test	YES	NO	When (Year)
Echocardiogram			
Stress Test			
Barium X Ray			
UGI or Barium Swallow			
Colonoscopy			
Flexible Sigmoidoscopy			
Upper Endoscopy			
Pneumonia Vaccine			
Hepatitis A Vaccine			
Hepatitis B Vaccine			
Influenza Vaccine			

«PName»	DOB” «PDOB»	ACCT: «PNumber»

Review of Systems

Please check any symptoms you have had in the last 6 months.

General	Breast	Genitourinary
□ Loss of appetite □ Chills □Fatigue □ Fever □Night Sweats □ Weight Gain □ Weight Loss	□Lump □Pain □Swelling	□ Blood in urine □Pain w/urination □ Flank pain □Frequency □ Hesitancy
Skin	**Heart and Blood Vessels**	**Musculoskeletal**
□Bruising □ Itching □Rash □Hair Loss	□ Fainting □ Chest Pain □ Shortness of Breath □ Irregular Heartbeat □ High Blood Pressure □ Palpitations □Leg Pain/Swelling	□ Back Pain □Joint Pain □ Joint Stiffness □Joint Swelling □ Muscle Cramps □Muscle Weakness
HEENT	**Gastrointestinal**	**Neurological**
□ Change in Vision □ Headache □ Eye Redness □ Decreased Hearing □Ringing in Ears □ Nose Bleed □Hoarseness □ Mouth Ulcers □Sore throat	□Abdominal Mass □Abdominal Pain □Black, Tarry stool □ Constipation □Change in bowels □ Diarrhea □Difficult/Painful Swallowing □ Food Intolerance □ Gas □ Heartburn □ Indigestion □Jaundice □ Nausea □Rectal bleeding □Vomiting □ Vomiting Blood	□ Decreased Memory □ Dizziness □ Incontinence of stool □ Seizures □ Stroke/Mini Stroke □ Tremor
Neck	**Endocrine**	**Psychiatric**
□ Lump □Pain □ Stiffness	□ Cold intolerance □Heat Intolerance □Excessive Thirst □ Hair changes □Hot Flashes □Thyroid problems	□ Anxiety □ Depression □Inability to concentrate □Mood Changes □Insomnia/Trouble Sleeping □ Panic Attacks □ Suicide Ideas/Plans
Lungs		**Hematology**
□ Cough □ Difficulty Breathing □Wheezing □ Coughing up Blood □ Coughing up Sputum		□ Abnormal Bleeding □ Anemia □ Blood clots □ Prolonged Bleeding

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION OR "PHI" (Protected Health Information) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is being provided to you as a requirement of the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how **Gastrointestinal & Liver Specialists of Tidewater, PLLC (GLST)** may use and disclose medical information about you to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control protected health information about you. Your personal health information (i.e., "protected health information" or "PHI" for any purposes of HIPAA) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition. We are required by law to maintain the privacy of your PHI, and we must abide by the terms of this notice.

We will use or disclose your PHI in ways consistent with what is stated in our Privacy Notice.

The ***effective date*** of this Privacy Notice is **April 14, 2003**.

We reserve the right to change the terms of this Privacy Notice and to make a new Privacy Notice effective for all PHI we maintain. In the event of a change to our Privacy Notice, we will provide you with the new Privacy Notice upon request.

We have designated a Privacy Officer whom you may consult to ask questions and bring up concerns you might have about your PHI and how it is handled. You can reach our **Privacy Officer by calling 757-466-0165 or writing to Digestive & Liver Disease Specialists, 885 Kempsville Rd., Suite 114, Norfolk, VA 23502**.

In this notice we provide descriptions of the different ways we may use and disclose your personal health information. In some cases, an example is provided to describe the types of uses and disclosures of your PHI that may be made by our organization; however, these examples are not intended to be inclusive of all the ways we may use your PHI.

ACKNOWLEDGMENT OF RECEIPT OF THIS PRIVACY NOTICE

You are receiving our current Privacy Notice and are asked to sign an acknowledgment that you have received it. You may provide the signed acknowledgment by: signing the last page of this Privacy Notice and returning it to reception desk or a nurse, physician or other staff member, or by mailing it to the following address**: Digestive & Liver Disease Specialists, 885 Kempsville Rd., Suite 114, Norfolk, VA 23502, Attention: Privacy Officer.**

If, after April 14, 2003, your initial contact with our office is through electronic mail, which may be available in the future, you will be asked to acknowledge receipt of this Privacy Notice by replying to our electronic message that contains the Privacy Notice and typing the following in your reply message: "I acknowledge receipt of the Privacy Notice", and including the date and your name.

HOW WE MAY USE AND DISCLOSE PHI ABOUT YOU

The following categories describe different ways that we use and disclose PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use and disclose your PHI as reasonably necessary to provide for your treatment. We do not need to obtain your permission, written or otherwise, for us to do this. We may disclose PHI about you to doctors, nurses, technicians or other healthcare personnel who are involved in taking care of you. For example, your primary care physician may need to know if we are treating you for a gastrointestinal complaint.

For Payment. We may use and disclose PHI about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a procedure performed in our office so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose PHI about you for healthcare operations. These uses and disclosures are necessary to run our office and make sure that all individuals receive quality care. Some examples of how we may use your PHI performing day-to-day tasks include utilizing a sign-in sheet at the front desk or calling you by name from the waiting room. We also may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you.

As another part of health care operations, we may use and disclose PHI about you to our business associates. Our business associates, such as transcription services, collection agencies and answering services perform service on behalf of our practice. Our business associates, who have access to PHI, agree to protect the privacy of your personal health information.

Appointment Reminders, Test Results. As a part of our health care operations, we may use and disclose PHI to contact you as a reminder that you have an appointment for treatment or medical care at our office. We may leave a message on an answering machine or voicemail system including your name, the name of the physician in which you have an appointment, the practice name and a reminder to bring your co-payment, insurance referral and/or medical records or x-rays to your appointment. GLST may also send appointment reminder cards or recall notices to the address you provided to us during registration with your name, the name of the physician in which you have an appointment, the practice name and a reminder to bring your co-payment, insurance referral and/or medical records or x-rays to your appointment.

We may contact you to discuss treatment and/or test results. If you are not available, we may leave a message using your name, the name of your physician and the practice name so you may return our call.

Individuals Involved in Your Care or Payment for Your Care. We may release PHI about you to a friend or family member who is involved in your medical care or who may accompany you to an appointment or procedure. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in a hospital.

Research. Under certain circumstances, we may use and disclose PHI about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of PHI, trying to balance the research needs with individuals' need for privacy of their PHI. Before we use or disclose PHI for research, the project will have been approved through this research approval process, but we may, however, disclose PHI about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the PHI they review does not leave our office. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.

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

To Avert a Serious Threat to Health or Safety. We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation. If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose PHI about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release PHI if asked to do so by a law enforcement official: In response to a court order, subpoena, warrant, summons or similar process; To identify or locate a suspect, fugitive, material witness, or missing person; About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; About a death we believe may be the result of criminal conduct; About criminal conduct at our office; and In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release PHI about an individual to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Pursuant to an Authorization. We will require a signed authorization form before we disclose your PHI to a third party for reasons other than those listed above. We will retain a copy of any signed authorization you give us that is attached to a request to us for your PHI. We will also keep a record of when, to whom and what we provided in response to the request for disclosure. If you have signed an authorization for us to use or disclose your PHI, and decide you want to revoke the authorization, you have the right to revoke it. You must revoke the specific authorization in writing and deliver it to the **Privacy Officer at Digestive & Liver Disease Specialists, 885 Kempsville Rd., Suite 114, Norfolk, VA 23502.** Before your revocation is effective. Once we receive the revocation, or have actual knowledge that you have revoked the authorization, we will make a note of it to assure that we do not make future disclosures pursuant to your original authorization.

YOUR RIGHTS REGARDING PHI ABOUT YOU

You have the following rights regarding PHI we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy PHI that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to the **Privacy Officer at Digestive & Liver Disease Specialists, 885 Kempsville Rd., Suite 114, Norfolk, VA 23502.** If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed. Another licensed health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for GLST.

To request an amendment, your request must be made in writing and submitted to the **Privacy Officer at Digestive & Liver Disease Specialists, 885 Kempsville Rd., Suite 114, Norfolk, VA 23502**. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: Was not created by us, unless the person or entity that created the information is no longer available to make the amendment; Is not part of the PHI kept by or for us; Is not part of the information which you would be permitted to inspect and copy; or Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures of your PHI that we have made. (We do not have to provide an accounting of disclosures made for treatment, payment or healthcare operations, or pursuant to a signed authorization or where you did not orally deny authorization, or of certain disclosures required by law.)

To request this list or accounting of disclosures, you must submit your request in writing to the **Privacy Officer at Digestive & Liver Disease Specialists, 885 Kempsville Rd., Suite 114, Norfolk, VA 23502.** Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing

the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the **Privacy Officer at Digestive & Liver Disease Specialists, 885 Kempsville Rd., Suite 114, Norfolk, VA 23502**. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the **Privacy Officer at Digestive & Liver Disease Specialists, 885 Kempsville Rd., Suite 114, Norfolk, VA 23502**. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, send your written request to the **Privacy Officer at Digestive & Liver Disease Specialists, 885 Kempsville Rd., Suite 114, Norfolk, VA 23502**.

Our current Privacy Notice will also be posted in our office for you to review.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us. To file a complaint with us, contact the Privacy Officer at 757-466-0165. All complaints must be submitted in writing to the **Privacy Officer at Digestive & Liver Disease Specialists, 885 Kempsville Rd., Suite 114, Norfolk, VA 23502.**

You also have the right to complain to the Office of Civil Rights. **You will not be penalized for filing a complaint.**

6.2019

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of Gastrointestinal & Liver Specialists of Tidewater, PLLC.

Patient's Name:

____

(Please Print)

Patient's Signature:

____

Date:

____

If patient is unable to sign, or, you are signing as the personal representative of the patient:

Personal Representative's Name:

____

(Please Print)

Relationship to the Patient:

____

Date:

____

- -

If you would like us to release your medical information to any person other than yourself or those authorized under HIPAA, please indicate that below:

Name of person authorized to receive your Protected Health Information:
Name____DOB ______________
Relationship to you: ___________________________________
Patients Signature: ___________________________________
Date: ______________________________

GLOSSARY

Business Associate is a person or entity who (i) on behalf of **Gastrointestinal & Liver Specialists of Tidewater** performs or assists in the performance of a function or activity involving the use or disclosure of PHI, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, repricing, or any other activity regulated by HIPAA; or (ii) provides, other than in the capacity of a member of the workforce of **GLST**, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services to or for **GLST** where the provision of such service involves the disclosure of PHI. "Workforce" means employees, volunteers, trainees and other persons whose work is directly controlled by **GLST** whether or not they are paid by **GLST**.

Covered Entity means a health plan, a health care clearinghouse and a health care provider who transmits PHI in electronic form in connection with a transaction to carry out financial or administrative activities related to health care. All covered entities must comply with HIPAA.

Designated Record Set means records maintained by or for GLST that are (i) medical and billing records, (ii) enrollment, payment, claims adjudication and case or medical management record systems, or (iii) used, in whole or in part, to make decisions about individuals.

Health Care Operations means activities that are related to the basic functions of GLST. Health care operations include (i) conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives, and related functions that do not include treatment; (ii) reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs in which students, trainees or practitioners in areas of health care learn under the supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing or credentialing activities; (iii) underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits; (iv) conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; (v) business planning and development; (vi) business management and administrative activities, including but not limited to, implementation and compliance with HIPAA, customer service, resolution of internal grievances, the sale, transfer, merger of consolidation of all or part of a covered entity with another covered entity, and creating de-identified information, a limited data set or fundraising.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Individual means the person who is the subject of the PHI.

Individually Identifiable Health Information means health information, including demographic information collected from an individual, that (i) is created or received by a covered entity, (ii) relates to the past, present or future physical or mental condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual, and (iii) identifies the individual or could be used to identify the individual.

Minimum Necessary means the least amount of PHI necessary for a person to perform his/her job functions.

Payment means the activities undertaken by health care providers and health plans to obtain or provide reimbursement for the provision of health care. These activities include, but are not limited to, (i) determinations of eligibility or coverage, and adjudication or subrogation of health benefit claims; (ii) risk adjusting amounts due based on enrollee health status and demographic characteristics; (iii) billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing; (iv) review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; (v) utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and (vi) disclosure to consumer reporting agencies of any of the following PHI relating to collection of premiums or reimbursement: (A) name and address, (B) date of birth, (C) social security number, (D) payment history, (E) account number and (F) name and address of the health care provider and/or health plan.

Personal Representative means a person authorized to act on behalf of an individual.

PHI means protected health information. PHI is individually identifiable health information that is (i) transmitted by electronic media, (ii) maintained as electronic media, or (iii) transmitted or maintained in any other form or medium, including but not limited to, paper and oral forms.

Privacy Rule means the rules relating to the privacy of individually identifiable health information.

Treatment means the provision, coordination or management of health care and related services by one or more health care providers, including the coordination and management of health care by a health care provider with a third party, consultation between health care providers relating to a patient, or the referral of a patient for health care from one health care provider to another.