Zocdoc

Feedback forms

Important information: Please read

The reviews on a provider's profile on Zocdoc are extremely important. Our reviews system is a closed-loop system so that only patients who have seen you through Zocdoc are allowed to review you.

However, in order to optimize your profile from the beginning of your time on the service, we allow for several of your current patients to provide the initial reviews for your profile. These patients simply have to complete the attached Feedback Form and sign a HIPAA-compliant authorization that explains that the purpose of the Feedback Form is to assist in marketing your medical services.

Once you fax or email the Feedback Forms back to Zocdoc, our team will post them to your profile in a timely manner.

Details: Your HIPAA-compliant authorization must explain that the Feedback Form (along with the patient's identifying information) will be shared with Zocdoc, that Zocdoc may process the Feedback Form outside of the United States, that Zocdoc will make the information in the form publicly available on its website, and that the information will remain public as long as Zocdoc decides to use the Feedback Form or the patient revokes his/her authorization. It is also important that your authorization explain to patients that even if they revoke their authorization and Zocdoc removes their information from its website, their information may nonetheless continue to be available elsewhere on the Internet as Zocdoc cannot prevent the copying and dissemination of information from its website.

Please note, it is your obligation, as the covered entity, to use a valid HIPAA-compliant authorization and you are ultimately responsible for the content of this authorization and for confirming that it is valid and complete. We have enclosed a sample authorization that you can use, as a helpful service only, but we cannot represent (since we are not your legal counsel) that it is valid under HIPAA or the applicable laws of any state.

Zocdoc

How was your visit?

Provider first and last name: _____

Patient first name: _____ **Patient last initial:** _____

Written reviews require your first name and last initial to appear next to this review on the Zocdoc website.

What did you think about your visit?

_____

_____

_____

_____

_____

Would you recommend this professional?

☐ ★★★★★ Highly recommended ☐ ★★★★☆ Probably ☐ ★★★☆☆ Maybe ☐ ★★☆☆☆ Probably not ☐ ★☆☆☆☆ Never

How would you rate this professional's bedside manner?

☐ ★★★★★ Excellent ☐ ★★★★☆ Good ☐ ★★★☆☆ Satisfactory ☐ ★★☆☆☆ Unsatisfactory ☐ ★☆☆☆☆ Awful

How long was the wait time in the office before you were seen?

☐ ★★★★★ Right away ☐ ★★★★☆ Less than 30 min. ☐ ★★★☆☆ Between 30~60 min. ☐ ★★☆☆☆ Over 1 hour ☐ ★☆☆☆☆ Over 2 hours

By signing this form you acknowledge that your provider gave you an authorization form explaining how this information would be used and processed (including outside of the United States), and that you have signed and returned that authorization.

Signature: _____ **Date:** _____

Thank you! Your responses will be visible on Zocdoc until Zocdoc elects to remove them or you revoke your authorization. To leave another review, please book your next appointment online at **www.zocdoc.com**.

Please return by fax to **(347) 281-7725** or by email to **sara.brandt@zocdoc.com**.

Zocdoc

Authorization for marketing uses and disclosures

Authorization to use and disclose protected health information about you

This is an important document. Please read carefully and only sign if you feel comfortable doing so.

You are a patient of _____ (your "Physician") at _____ (our "Medical Group"). Our Medical Group is listed on a physician-searching website, called Zocdoc. Patients, such as you, can use Zocdoc to find doctors and schedule appointments. Zocdoc encourages physicians who are listed on its website to share patient reviews so that potential patients can consider this feedback in choosing a potential physician. You are being asked by the Medical Group to complete a Patient Feedback Form about your Physician and to let our Medical Group share that Patient Feedback Form with Zocdoc to market the services that your Physician provides. The Patient Feedback Form will contain information that could identify you (such as your name) and may reveal information about your health, for example, the type of doctor you are seeing. It will also include the feedback information that you choose to provide.

By signing this form, you allow the Medical Group to disclose the Patient Feedback Form to Zocdoc. The Medical Group will not disclose, pursuant to this authorization, any additional information besides what is on the Patient Feedback Form. Once Zocdoc receives your Patient Feedback Form, you understand that it will decide whether to post your feedback on its website. If it does post the feedback, your first name and last initial may also be disclosed along with any other information in the Patient Feedback Form. Your decision to sign this permission form allows Zocdoc to use and share your Patient Feedback Form in connection with marketing the Physician and Medical Group's services. You understand and agree that Zocdoc may process the Patient Feedback Form outside of the United States.

This permission form does not expire. If you decide you want to revoke this permission, you may do so anytime by contacting the person listed below, who will inform Zocdoc to remove the feedback from its website. Please note that your decision to cancel your permission for Zocdoc to use and share your Patient Feedback Form will only apply to future availability of your feedback on the Zocdoc website and will not affect the presence of your feedback on cached, archived, or similarly saved versions of the Zocdoc website. You should also understand that state or federal law may allow someone who gets your information from the Zocdoc website to use or release it in some way not discussed in this form. In addition, even if you revoke your permission and Zocdoc removes your feedback from its website, your information may already have been copied and shared elsewhere on the internet or in other ways. Zocdoc will not be able to withdraw that information or prevent it from being seen or shared.

It is important to remember that not signing this form or later canceling your permission will not affect your health care treatment from your Physician, payment for health care from a health plan, or your ability to get health plan benefits.

I have read this form. I understand it and agree to its terms.

First and last name: _____

Signature: _____ **Date:** _____

You or your personal representative's* name

***My authority to sign as the Personal Representative of the Persons giving this permission is as:**

You or your personal representative's* signature

☐ **Parent** ☐ **Legal guardian** ☐ **Power of attorney** ☐ **Other:**

Revocation contact person: _____

Please return by fax to **(347) 281-7725** or by email to **sara.brandt@zocdoc.com.**