PATIENT AGREEMENT

This Agreement is entered into on _____, by and between Altucare Primary Medical Care, PLLC, located at 682 E Main St., Suite 2A, Middletown, NY 10940, and _____ ("Member").

BACKGROUND

Through its physician employees, Altucare Primary Medical Care, PLLC delivers health care services at the address set forth above. In exchange for fees, Altucare Primary Medical Care, PLLC agrees to provide Member with the Services described within this Agreement, on the terms and conditions set forth in this Agreement.

DEFINITIONS

1. **Ancillary Fees:** As used in this Agreement, fees other than Membership Fee charged for ancillary services provided by Altucare Primary Medical Care, PLLC. These may include items such as Sick Visits in excess of the number allowed under this Agreement, laboratory fees for services not covered by the Membership Fee, prescription medications, dietary supplements, medical equipment and supplies, shipping and/or handling fees associated with these services, and any diagnostic or treatment services that are not explicitly described in Appendix A of this agreement.
2. **Communications:** As used in this Agreement, the various means available for communication between Member and Altucare Primary Medical Care, PLLC. Options include voice (cell or land-line phone), digital (e-mail, facsimile, or text messaging), and/or virtual (video chat or other "Skype" like services).
3. **Health Care Plan (HCP):** As used in this Agreement, any medical insurance or third party payment / reimbursement plan of which Member may be a subscriber or enrollee, designed to pay Member healthcare / medical expenses.
4. **Member Services:** As used in this Agreement, the package of health care and related services described in Member Services / Membership Fee (Appendix A), which is attached to this Agreement, and incorporated by reference.
5. **Membership Fee:** As used in this Agreement, monthly payment made by Member to Altucare Primary Medical Care, PLLC for Member Services provided to Member.
6. **Physician:** means Jennifer Vazquez-Bryan, M.D., or any other physician employed by Altucare Primary Medical Care, PLLC to perform Membership Services.

7. **Sick Visits**: as used in this Agreement, refers to visits that are a result of the Member's illness or injury.
8. **Well Visits**: as used in this Agreement, refers to Member's preventative encounters with the Altucare Primary Medical Care, PLLC or Member's visits with the Altucare Primary Medical Care, PLLC that are not a result of the Member being ill or injured.

ACKNOWLEDGMENTS

1. **Insurance Plan Disclaimer:** Member acknowledges that this Agreement covers only limited, routine health care services as designated in the Agreement, and is not and does not constitute (1) an insurance plan; or (2) a medical plan that provides health insurance coverage for purposes of the Federal Patient Protection and Affordable Care Act; or (3) any other contract for the purpose of spreading and/or underwriting risk, as defined by the promulgated rules, regulations, and opinions of the New York State Department of Financial Services and/or its predecessor agencies. Member specifically acknowledges and understands that, as more fully stated in Appendix "A", Member is **not** entitled to an unlimited amount of Sick Visits under the Agreement, and that this Agreement will not cover hospital services or any services not personally provided by Altucare Primary Medical Care, PLLC and/or Physician. Member acknowledges that Altucare Primary Medical Care, PLLC has advised Member to obtain or keep in full force a HCP to cover Member for health care costs incurred outside of this Agreement, and that this Agreement is not intended to replace any existing or future HCP.

2. **Insurance Participation:** Member acknowledges that Altucare Primary Medical Care, PLLC and Physician are not participating providers with any HCP of which Member may be a subscriber or enrollee. Neither Altucare Primary Medical Care, PLLC, nor Physician, will bill any HCP of which Member may be a subscriber or enrollee, for Membership Fee or any Ancillary Fees. Member further acknowledges that as a condition of entering into and maintaining this Agreement, Member will not seek reimbursement from any HCP for any fees paid to Altucare Primary Medical Care, PLLC. If Member seeks reimbursement from any HCP for any fees due under the terms of this Agreement, this Agreement will terminate immediately.

3. **Medicare/Medicaid:** MEMBER acknowledges and understands that Altucare Primary Medical Care, PLLC and Physician have OPTED OUT OF MEDICARE/MEDICAID. **This means that Medicare/Medicaid can not be billed for any services performed for Member by Altucare Primary Medical Care, PLLC or Physician**. Member agrees not to make any attempt to collect reimbursement from Medicare/Medicaid for any services provided by Altucare Primary Medical Care, PLLC or Physician. If Member is eligible for Medicare/Medicaid, or during the term of this Agreement becomes eligible for Medicare/Medicaid, Member will be required to notify Altucare Primary Medical Care, PLLC and annually sign a Medicare/Medicaid opt-out agreement form (Appendix B).

Member's failure to notify Altucare Primary Medical Care, PLLC and sign the opt-out agreement results in this Agreement becoming null and void.

4. **Fees:** Membership Fee is due monthly, in the amount specified in Appendix A. Ancillary Fees are due at the time of service.

5. **Term; Termination:** Unless otherwise specified, Agreement will commence on the date of this Agreement. Member or Altucare Primary Medical Care, PLLC shall have the absolute and unconditional right to terminate this Agreement upon written notice to the other party. Unless terminated as above, this Agreement will automatically renew on a monthly basis upon receipt of monthly Membership Fee, which is due at the end of the month in which services are be rendered.

6. **Privacy:** Member must sign the Patient Notice of Privacy Practice attached as Appendix "C".

7. **Regular Appointments:** appointments are required to be made by Member at least 24 hours' in advance. Each Member must present photo identification each visit.

8. **Communications:** Member may be contacted at the following email address:

_____@_____.____

Member, by providing Member's email address herein, authorizes Altucare Primary Medical Care, PLLC to communicate with Member, or parent/legal guardian if Member is a minor, regarding Member's Personal Healthcare Information (PHI), as defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations. Altucare Primary Medical Care, PLLC will make every reasonable effort to keep Communications confidential and secure. Member acknowledges that not all Communication options can be guaranteed to be confidential and secure. As such, Member expressly waives Altucare Primary Medical Care, PLLC's obligation to ensure confidentiality with respect to Communications. Member additionally acknowledges:

1. If Member sends or receives Communications through an employer's communication system, these Communications may become the property of the employer, and available for employer's review.

2. At the discretion of Altucare Primary Medical Care, PLLC, Communications may be made a part of Member's permanent medical record.

3. If Member attempts to communicate with Altucare Primary Medical Care, PLLC either digitally or virtually, and has not received a response within two

business days, Member agrees to use one of the voice options of communication to contact Altucare Primary Medical Care, PLLC. Altucare Primary Medical Care, PLLC will not be liable to Member for any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to Member as a result of technical failures, including, but not limited to: technical failures attributable to any internet service provider; power outages; failure of any electronic messaging software; failure to properly address e-mail messages; failure of Altucare Primary Medical Care, PLLC computers or computer network; faulty telephone or cable data transmission; any interception of Communications by a third party; Member failure to comply with the guidelines set forth in this section.

9. **Medical Treatment in the Event of Emergency**: Member understands that not all methods of treatment offered under this Agreement may be appropriate in the event of an emergency, or a situation in which the Member could reasonably expect to develop into an emergency. Member acknowledges that Altucare Primary Medical Care, PLLC has informed Member that in such circumstances (1) waiting to be treated at a Regular Appointment with Physician is not medically advisable; and (2) that not all communication options referenced in Paragraph 9 of this Agreement may be an appropriate means of communication regarding emergent medical care, time-sensitive issues, or for inquiries regarding sensitive information. **Member understands and agrees that in the event of an emergency**, Member shall call 911, or proceed to the nearest hospital-based Emergency Department, and follow the directions of emergency personnel.

10. **Change of Law:** If there is a change of any law, regulation or rule, federal, state or local, which affects this Agreement, any terms or conditions incorporated by reference in the Agreement, the activities of either party under the Agreement, or any change in the judicial or administrative interpretation of any such law, regulation or rule, and either party reasonably believes in good faith that the change will have a substantial adverse effect on that party's rights, obligations or operations associated with the Agreement, then that party may, upon written notice, require the other party to enter into good faith negotiations to renegotiate the terms of the Agreement. If the parties are unable to reach an agreement concerning the modification of the Agreement within forty-five days after the effective date of change, then either party may immediately terminate the Agreement by written notice to the other party.

11. **Severability:** If for any reason any provision of this Agreement shall be deemed, by a court of competent jurisdiction, to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of the Agreement shall not be affected, and that provision shall be deemed modified to the minimum extent necessary to make that provision consistent with applicable law in its modified form, and that provision shall then be enforceable.

12. **Reimbursement For Services Rendered:** If this Agreement is held to be invalid for any reason, and Altucare Primary Medical Care, PLLC is required to refund all or any portion of the monthly Fees paid by Member, Member agrees to pay Altucare Primary Medical Care, PLLC an amount equal to the reasonable value of the Services actually rendered to Member during the period of time for which Fees are required to be refunded.

13. **Amendment:** No amendment of this Agreement shall be binding on any party unless it is made in writing and signed by all the parties. Notwithstanding the foregoing, Altucare Primary Medical Care, PLLC may unilaterally amend this Agreement to the extent required by federal, state, or local law or regulation (Applicable Law), by sending Member thirty days advance written notice of such change. Moreover, if Applicable Law requires this Agreement to contain provisions that are not expressly set forth in this Agreement, then, to the extent necessary, such provisions shall be incorporated by reference into this Agreement and shall be deemed a part of this Agreement as though they had been expressly set forth in this Agreement.

14. **Assignment:** This Agreement, and any rights Member may have under it, may not be assigned or transferred by Member.

15. **Relationship of Parties:** Member, Altucare Primary Medical Care, PLLC, and Physician intend and agree that Physician, in performing his duties under this Agreement, is an employee of Altucare Primary Medical Care, PLLC as defined by the guidelines promulgated by the United States Internal Revenue Service and/or the United States Department of Labor.

16. **Legal Significance:** Member acknowledges that this Agreement is a legal document and creates certain rights and responsibilities. Member also acknowledges that Member has had reasonable time to seek legal advice regarding this Agreement and has either chosen not to do so, or has done so and is satisfied with the Agreement's terms and conditions.

17. **Miscellaneous:** This Agreement shall be construed without regard to any presumptions or rules requiring construction against the party causing the instrument to be drafted. Captions in this Agreement are used for convenience only and shall not limit, broaden, or qualify the text.

18. **Entire Agreement:** This Agreement contains the entire agreement between the parties and supersedes all prior oral and written understandings and agreements regarding the subject matter of this Agreement.

19. **Jurisdiction:** This Agreement shall be governed and construed under the laws of the State of New York. Any disagreement not covered by the Arbitration clause of this Agreement shall be subject to the exclusive jurisdiction of the courts of the State of New York, County of Kings.

20. **Arbitration:** All fee disputes arising out of this Agreement will be submitted to arbitration in the county which the Physician is located, pursuant to the rules of the American Arbitration Association located in the State of New York. The decision in arbitration shall be conclusive and binding on the parties and may be reduced to judgment in any court of competent jurisdiction. The parties expressly waive their right to trial in any court.
21. **Service:** All written notices are deemed served if sent by first class U.S. mail to the addresses recorded below:

    If to Altucare Primary Medical Care, PLLC:

    Altucare Primary Medical Care, PLLC

    682 E Main St.

    Suite 2A

    Middletown, NY, 10940

    If to Patient:

    _____

    _____

    _____

    _____

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of the day and year first above written.

Altucare Primary Medical Care, PLLC Patient

_____ _____

By: By:

APPENDIX "A"

1. **Membership Pricing:** the following is the fee schedule as currently set by the Altucare Primary Medical Care, PLLC:

Children 0-18 Years -	$20 per month
Adults 19-64 Years -	$60 per month
After hours visits -	$50 per visit
Home visits -	$75 per visit, only available for newborns and patients 65+
Re-initiation fee -	$200

2. **Member Services:** All Members in good standing are entitled to unlimited Well Visits (at clinic, during regular hours) and communications (email, phone, text) without any additional fees. Member will be allowed up to 8 Sick Visits per month, and any additional Sick Visits will be charged at the rate of $ 20 per visit. MEMBER UNDERSTANDS THAT THIS AGREEMENT **DOES NOT** COVER HOSPITAL STAYS, EMERGENCY ROOM VISITS, SERVICES OF NON-PC SPECIALISTS OR TREATMENT PROVIDED ANYWHERE BUT THE Altucare Primary Medical Care, PLLC'S FACILITY. Certain procedures will be charged under a separate fee schedule, which will be provided with this Agreement. Labs and tests included in the monthly membership include:

   - Urinalysis
   - EKG
   - rapid strep
   - random glucose
   - pregnancy test

   ALL OTHER LAB TESTS would be charged under a set rate or be processed through the Member's private insurance.

3. **Prescription Medications**: are not included and would be processed through the Member's private insurance.

4. **Vaccines**:

   Flu vaccine - $15

Childhood Vaccines - processed through insurance.

5. **<u>Other procedures</u>**:

Ear wax removal - FREE
Skin tag removal- FREE
Abscess Drainage - $20
Wart Freezing - $10
Wart injection - $10
Mole removal/Skin biopsy* - $10-20 *Additional separate cost for pathology
Wound repair (stitches, glue) - $20
Ingrown toenail - $20
Joint Injection (steroid) knee - $20, shoulder - $20
Splint - $20
Cast - $20
IUD removal- $10
IUD insertion- $30, not including the cost of the IUD.
Depo Provera injection- $10
TB skin test- $10

Appendix B

Medicare/Medicaid Opt Out Agreement

This agreement ("Agreement") is entered into by and between **Altucare Primary Medical Care, PLLC**, owned and operated by Dr. Jennifer Vazquez-Bryan (the "Physician"), whose principal medical office is located at 682 East Main Street, Suite 2A, Middletown, NY, 10940, and _____, a beneficiary enrolled in Medicare Part B or Medicaid ("Beneficiary"), who resides at _____, _____.

Introduction

The Balanced Budget Act of 1997 allows physicians to "opt out" of Medicare/Medicaid and enter into private contracts with patients who are Medicare/Medicaid beneficiaries. In essence, the physician must agree not to submit any Medicare/Medicaid claims nor receive any payment from Medicare/Medicaid for items or services provided to any Medicare/Medicaid beneficiary.

This Agreement between Beneficiary and Physician is intended to be the contract physicians are required to have with Medicare/Medicaid beneficiaries when physicians opt-out of Medicare/Medicaid. This Agreement is limited to the financial agreement between Physician and Beneficiary and is not intended to obligate either party to a specific course or duration of treatment.

Physician Responsibilities

(1) Physician agrees to provide Beneficiary such treatment as may be mutually agreed upon and at mutually agreed upon fees.

(2) Physician agrees not to submit any claims under the Medicare/Medicaid program for any items or services, even if such items or services are otherwise covered by Medicare/Medicaid.

(3) Physician agrees not to execute this contract at a time when Beneficiary is facing an emergency or urgent healthcare situation.

(4) Physician agrees to provide Beneficiary with a signed copy of this document before items or services are furnished to Beneficiary under its terms. Physician also agrees to retain a copy of this document for the duration of the opt-out period.

(5) Physician agrees to submit copies of this contract to the Centers for Medicare and Medicaid Services (CMS) upon the request of CMS.

Beneficiary Responsibilities

(1) Beneficiary agrees to pay for all items or services furnished by Physician and understands that no reimbursement will be provided under the Medicare/Medicaid program for such items or services.

(2) Beneficiary understands that no limits under the Medicare/Medicaid program apply to amounts that may be charged by Physician for such items or services.

(3) Beneficiary agrees not to submit a claim to Medicare/Medicaid and not to ask Physician to submit a claim to Medicare/Medicaid.

(4) Beneficiary understands that Medicare/Medicaid payment will not be made for any items or services furnished by Physician that otherwise would have been covered by Medicare/Medicaid if there were no private contract and a proper Medicare/Medicaid claim had been submitted.

(5) Beneficiary understands that Beneficiary has the right to obtain Medicare-covered/Medicaid-covered items and services from physicians and practitioners who have not opted out of Medicare/Medicaid, and that Beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered/Medicaid-covered items and services furnished by other physicians or practitioners who have not opted out of Medicare/Medicaid.

(6) Beneficiary understands that Medigap plans (under section 1882 of the Social Security Act) do not, and other supplemental insurance plans may elect not to, make payments for such items and services not paid for by Medicare/Medicaid.

(7) Beneficiary understands that CMS has the right to obtain copies of this contract upon request.

This contract becomes effective on _____, and will continue in effect until _____. Either party may terminate treatment with reasonable notice to the other party. Notwithstanding this right to terminate treatment, both Physician and Beneficiary agree that the obligation not to pursue Medicare reimbursement for items and services provided under this contract will survive this contract.

Altucare Primary Medical Care

By: _____
Dr. Jennifer Vazquez-Bryan

_____
Date Signed by Physician and PLLC

_____
Name of Beneficiary (Printed)

_____
Signature of Beneficiary

_____
Date Signed

Appendix C

Notice of Privacy Practices

Effective date: February 22, 2016

Altucare Primary Medical Care, PLLC

Privacy Officer to contact for further information:
Jennifer Vazquez-Bryan, MD
682 East Main St, Suite 2A, Middletown, NY 10940
845-510-1870

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.
Please read carefully.

WHAT IS HIPAA? The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a law designed to protect patient's protected health information (PHI). The U.S. Department of Health and Human Services ("HHS") issued a Privacy Rule to implement the requirement of HIPAA regarding the use and disclosure of individual's PHI by organizations subject to the Privacy Rule — called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used.

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time. We realize that these laws are complicated, but we are required by Federal law to provide you with the following important information:

- **How we may use and disclose your PHI,**
- **Your privacy rights in your PHI,**

• **Our obligations concerning the use and disclosure of your PHI.**

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact our "Privacy Officer" designated above.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Optional Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Optional Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. Optional Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. Optional Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.
8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also

may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Optional Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Optional Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Optional Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:
You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to our "Privacy Officer" designated above, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the "Privacy Officer" designated above. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the "Privacy Officer" designated above, in order to inspect and/or obtain a copy of your PHI. Our practice may charge

a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the "Privacy Officer" designated above. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the "Privacy Officer" designated above. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the "Privacy Officer" designated above.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the "Privacy Officer" designated above. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your

authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the "Privacy Officer" designated above.

_____ Date: _____
Sign and date to acknowledge that you have read and understand your rights.