DIRECT PRIMARY CARE PATIENT AGREEMENT
Jinnah Internal Medicine, LLC

This is an Agreement between Jinnah Internal Medicine, LLC (Practice), Dr. Shehzad Jinnah, M.D. (Dr. Jinnah), and _____ (Patient or Patient's Representative for Patient, or You or Your).

Background:

Dr. Jinnah provides internal medicine services through the Practice. He would be honored to be Your care provider. With that in mind he agrees to provide you the Services described in this agreement on the terms and conditions below. Additional information regarding Dr. Jinnah, the Practice, and the care they provide can be found on the Practice's website at https://www.jinnahmd.com.

Agreement:

What We'll Do. We will provide You the basic ongoing primary care services described under the SERVICES heading below (collectively Services). We'll let You know how and when You may contact Dr. Jinnah via phone, email, and otherwise. Dr. Jinnah will make every effort to address Your needs in a timely manner, but cannot guarantee immediate availability, and cannot guarantee that You won't need to seek treatment in an urgent care, emergency department, or hospital setting. If so, those costs will not be included in Your membership.

What We Charge. You'll pay the Practice the amounts described in the Fee Schedule below. Though we aim for pricing stability, we must reserve the right to increase our fees. Of course, we will let you know before doing so.

Cancellation & Refund Policy. You can cancel Your membership at any time and the membership will be terminated at the end of the last calendar month paid. There is no cancellation fee or charge.

We Do Not Take Insurance. Dr. Jinnah and the Practice have made a very conscious decision NOT TO ACCEPT OR PARTICIPATE IN ANY INSURANCE PRODUCTS OR PROGRAMS. You should therefore anticipate that the fees You pay for Services will not be covered by any insurance you may have. In the same vein' Dr. Jinnah has opted out of Medicare. So, if You are a Medicare enrollee you acknowledge and understand that Medicare will NOT cover the Services provided by Dr. Jinnah and the practice. Rather, You must pay for the Services out of Your own pocket, and neither Medicare nor Medicare Advantage nor MediGap policies will reimburse You for these costs. Note, Medicare eligible patients must sign the acknowledgment at Appendix 1.

And We Are Not Insurance. It's important You understand that this agreement and the Services arrangement it describes are NOT an insurance plan, or a substitute for health insurance or other health plan coverage. We do NOT cover hospital, surgery center, or similar services, or any other medical needs not personally provided by Dr. Jinnah described below. It is therefore vital You obtain and keep in full force health insurance policy(ies) or plan(s) that will cover facility fees (hospitals and urgent care offices, for example) and general health care costs not included in the services.

Certification. The Department of Consumer and Business Services issued a certification to this practice. You can contact consumer advocates at the Department of Consumer and Business Services at (888) 977-4894, dcbs.insmail@state.or.us, or www.insurance.oregon.gov.

Our Availability. our goal is to be available to You when You need us. However, you should understand this agreement is only for the ongoing primary care Services described. You may need to visit the emergency room, hospital, or urgent care from time to time-and as noted already those costs are not included in the Services, Dr. Jinnah will, however, make every effort to be available via phone, email, and through other methods when needed--but he cannot, of course, guarantee 24/7 availability.

Disclaimer. This agreement does not provide health insurance coverage, including the minimal essential coverage required by applicable federal law. It provides only the Services described. It is therefore essential that You obtain and maintain health care insurance to cover medical services not provided for under this agreement. You should note that employer benefits and tax-advantaged health benefits opportunities may not be used to pay membership

fees. You should contact your employer, tax advisor, or health insurance representative regarding the use of HRA, HSA, FSA, medical reimbursement plan, and cafeteria plan benefits to pay Your membership fees.

Term. Your right to Services begins the day You make Your first membership payment, unless we otherwise agree in writing, and continues monthly thereafter so long as you continue making timely payments. Either You or we may terminate the agreement any time. If we terminate, we'll advise you in writing 30 days in advance. You may terminate with 24 hours' prior notice. Upon termination, pre-paid future membership fees will be promptly refunded.

Reasons the Practice may terminate this agreement on 30 days' prior notice may include but are not limited to:

- You fail to pay applicable fees owed pursuant to the Fee Schedule;

- You act fraudulently;

- You repeatedly fail to adhere to the recommended treatment plan, especially regarding the use of controlled substances;

- You are abusive, or present an emotional or physical danger to the Practice's staff or other patients;

and

- The Practice closes its doors.

Of course, the Practice also may terminate a Patient without a specific reason as long as the termination is handled appropriately (per protocols consistent with patient-abandonment concerns). Likewise, the Practice may decide whom to accept as a patient, just as patients have the right to choose their physician.

PERIODIC & ENROLLMENT FEES. This agreement is for the ongoing primary care services described below' It is not health insurance. You may need additional care provided through specialists, hospitals, ERS, surgery centers' and/or urgent care centers. Those facilities and services are outside the scope of this agreement. You may also need tests, scans, therapies and other diagnostics or care that are not covered by this agreement- You will be responsible for paying for these to the extent they are not covered by separate insurance you have obtained.

Enrollment Fee - You pay a non-refundable $300 fee to enroll. If You discontinue your membership for any reason, and later request to re-enroll we may decline re-enrollment. If we welcome you back, you will be required to pay a new enrollment fee.

Monthly Membership Fee - The monthly membership fee is for the ongoing primary care services we offer' we prefer that You schedule visits more than24hours in advance when possible. And note, we do not provide walk-in urgent care services.

Monthly periodic fees are:

- $70 per month for patients 17 years of age to 44 years of age.
- $110 per month for patients ages 45 through 64.
- $150 per month for patients 65 years of age and older.
  Bonus If you prepay for a 12 month period you receive a one-month discount!

SERVICES: Summary of What You Can Expect From Your Membership.

Ongoing Primary Care and In-Office Procedures, There are no fees for office visits. Available in-office procedures are included for no additional fee, See the List of Services that follows.

Pathology. Pathology studies such as biopsies and pap smears will be ordered at Your cost, always in the most economical manner possible.

Surgery and Specialist Referrals and Consults. Outside consults will be available at Your cost, requested only in consultation with You, and generally arranged as quickly as possible and in the most economical manner available.

After-Hours Visits. Though Dr. Jinnah cannot guarantee after-hours availability, he will make reasonable efforts to be available electronically and by phone as-needed after hours.

Acceptance of Patients. Dr. Jinnah must reserve the right to accept or decline patients. Common reasons for declining to accept a patient include our inability to appropriately handle a patient's needs and the need to close the practice to new patients to avoid over-crowding.

REMINDER: Emergency, hospital, and obstetric services, among others, are NOT apart of Your membership. Dr. Jinnah may in some situations be available to visit You when hospitalized, but Dr. Jinnah will not write orders in-hospital.

LIST OF SERVICES (Primary Care-- office appropriate)

Basic Care	Wellness Exams including Sports Physicals	Included
	Basic Internal Medicine Care-Office Visits	Included
	Preventative Care & Tests Planning	Included
Acute Care	Urinary Problems	Included
	Respiratory Infections	Included
	Gastrointestinal Problems	Included
	Injuries (where office care is appropriate)	Included
Procedures	EKG	Included
	Joint injections (knee, shoulder, hip, elbow, finger, etc,)	Included
	Skin Lesion Excision & Biopsy (does not include pathology fee)	Included
	Smail laceration repairs, except face, scalp and other areas Dr. Jinnah deems inappropriate for an office procedure	Included
	Pap Smears/HPV Testing	Included Additional Lab Fee
	Abscess Drainage	Included
	Nebulizer Treatments	Included
Complex Care	Diabetes Management	Included
	Hypertension Management	Included
	Hyperlipidemia (cholesterol) Management	Included
	Rheumatology Management	Included
	Thyroid Disorders and Endocrine Management	Included

	Cardiovascular and Pulmonary Disease Management	Included
	Gastrointestinal Disorder Management	Included
	Neurology Management	Included
	Mental Health/Wellness Care	Included
	Hospital Follow-Up and Pre-Op Evaluations	Included
	Weight Management Planning	Included
Labs/Imaging	Urinalysis	Included
	Urine Pregnancy Test	Included
	Rapid Strep Testing	Included
Premium Access	Same Day/Next Day Office Visits	Included
	Telemedicine Visits (email, phone, text, video chat)	Included

Dr. Jinnah may offer other office-based internal medicine health care services and procedures and may charge an extra fee for the services to those members who wish to take advantage of them. Dr. Jinnah will, of course let You know about new offerings and any related fees as appropriate.

Severability. If for any reason any provisions of this agreement are invalid or unenforceable, the validity of the remaining provisions will not be affected, and the invalid or unenforceable provision will be deemed modified to the minimum extent necessary to make it consistent with applicable law, and it will then be enforceable.

C**ommunications and Privacy.** Dr.Jinnah and the Practice are concerned about your privacy. you will receive a Notice of Privacy Practices when You become a member, describing our privacy protocols. It is important that You understand up front that communications with Dr. Jinnah-using email, video chat, instant messaging, and cell phones are not guaranteed to be secure. While encryption may be available on some platforms, it is not available in many, and it often requires that both parties to the conversation implement protections. Therefore, if You want to be sure a communication is secure, you should see Dr. Jinnah in person. Note, if You include Your health information in an unencrypted communication, You agree You are instructing Dr.Jinnah to respond to you using the same unprotected format.

Reimbursement for services if Agreement is Invalidated. If this agreement is held to be invalid for any reason the Practice is therefore required to refund all or any portion of the monthly fees you paid, you agree that You will immediately pay the Practice an amount equal to the fair market value of the services rendered to you during the period covered by the refunded fees.

Reimbursement in the Event the Practice can't Provide promised Services. If for any reason the practice becomes unable to provide Services for which You have pre-paid for the year, the practice will return your pre-paid future months in full.

Assignment. You may not transfer or assign this agreement, or Your rights under it, to any other person. The Practice may assign this agreement to a successor medical practice if Dr.Jinnah provides medical services for the medical practice.

Jurisdiction. This agreement shall be governed and construed under the laws of the State of Oregon and all disputes arising out of this agreement shall be resolved in court of proper venue and jurisdiction for the Practice.

Patient Understanding (initial each):

_____ I understand the Department of consumer and Business Services issued a certification to this Practice. I may contact consumer advocates and the Department of Consumer and Business at (888) 977-4894, dcbsinsmail@state.or.us, or www.insurance.oregon.gov.

_____ I understand I may cancel my Membership at any time on at least 24 hours' prior notice. I further understand that upon termination of my membership, for any reason, pre-paid future membership fees will be promptly refunded. For example, if in January I prepay for the entire year, and my membership terminates in April, the Practice will refund me full amount I paid less four times my monthly periodic fee. I understand refunds will not be made for partial months.

_____ I understand that I must pay for each membership month no later than the first of the month unless I choose to prepay for a year, in which case I will receive a one-month discount.

_____ I understand this agreement and my membership covers only the outgoing primary care services described in the LIST OF SERVICES, and that this arrangement is not medical insurance. I understand I must pay for all medical services not included in LIST OF SERVICES.

_____ I do NOT have an emergent medical problem at this time.

_____ I am enrolling for membership in the Practice voluntarily, I understand I have other healthcare options.

_____ In the event of a medical emergency I agree to call 911 first.

_____ I understand I will be required to pay all medical costs to the extent they are not covered Services and are not covered by medical insurance I have obtained.

_____ I understand Dr.Jinnah will make reasonable efforts to be available when I have basic medical needs, but he may not always be able to see me on a same-day basis. I may, rarely, be referred to an urgent care for same-day services and in those circumstances I will have to pay for those services to the extent they are not covered by insurance I have.

_____ I understand the from time to time Dr.Jinnah will be unavailable, and that during these times I will be given the opportunity to consult with another physician at no additional cost.

_____ I understand the Practice will not file or fight any insurance claims on my behalf.

_____ I understand this agreement does not meet the Affordable Care Act's individual insurance requirements.

_____ I do NOT expect the Practice to prescribe chronic controller substance except when Dr.Jinnah determines they are medically appropriate. (These include commonly abused opioid medications, benzodiazepines, and stimulants.)

_____ I understand failure to pay the membership fee will result in termination from the Practice.

Patient Name:_____ **Date:**_____

Patient Signature:_____

(or legal representative or guardian, if applicable)

Jinnah Internal Medicine, LCC

By:_____ _____

Shehzad Jinnah, M.D., Member Shehzad Jinnah, M.D., Personally

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Print Name of Patient (First,Middle,Last)	**Birthday (mm/dd/yyyy)**
Address(Street Address, City, State, Zip Code)	
Phone Number	**E-Mail**

I hereby authorize the following heath care professional, medical facility, medical health facility, laboratory, paramedical facility, medical examiner, medical records services, prescription history clearing house, consumer reporting agency, or employer, to release all health information about me:

Person/Organization to Release Information	
Address(Street Address, City, State, Zip Code)	
Phone Number	**Fax Number**

The following person/organization is hereby authorized to receive my entire medical records, treatment records and diagnostic records to the following person or organization:

Person/Organization to Release Information **Jinnah Internal Medicine, LLC**	
Address(Street Address, City, State, Zip Code) **2840 Crescent Ave, Suite 500 Eugene, OR 97408**	
Phone Number **541-359-3770**	**Fax Number** **541-359-3722**

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

The following health information that relates to service beginning from _____to _____, may be released:

- Entire Medical Records including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.

I further understand that my medical record may include one or more of the following:

- Treatment of communicable diseases, Including sexually transmitted disease, venereal diseases, tuberculosis, or hepatitis
- HIV-Related Treatment
- Mental Health Information or Psychological Conditions
- Alcohol or Substance Abuse Treatment
- Genetic Testing

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf. May need to obtain, use or disclose any and all information about my physical and mental health, including but no limited to services for preventative, diagnosis and therapeutic care, tests, counseling, and medical prescription for the purpose of:

☐ Change of Doctor ☐ Other _____

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law. This authorization is valid for 24 months following the date of my signature shown below, A copy, electronic copy, image, or facsimile of this authorization is as valid as the original, I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information. I have read(or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient or Personal Representative:	Date Signed:	Description of Personal Representative's Authority:

APPENDIX 1:

Medicare Patient Acknowledgement

Member is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Practice has informed Member or his/her legal representative that Dr. Jinnah and the Practice have opted out of the Medicare program.

Note" Dr. Jinnah has never been excluded from participating in Medicare Part B under [1 128] 1 128, [1156] 1156, or [1892] l8g2oftheSocialSecurityAct; he simply has elected to opt out as a provider in the program.

Member or his/her legal representative agrees, understands and expressly acknowledges the following **(initial each):**

_____ Member or legal representative accepts full responsibility for payment of the Practice's membership fees.

_____ Member or legal representative understands that Medicare limits do not apply to what the Practice may charge for the Service.

_____ Member or legal representative agrees not to submit a claim to Medicare or to ask the practice to submit a claim to Medicare.

_____ Member or legal representative understands that Medicare payment will not be made for any of the Services furnished by Dr. Jinnah that would have otherwise been covered by Medicare if there was No private contract and a proper Medicare claim had been submitted.

_____ Member or legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from practitioner, who have not opted out of Medicare, and member is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other practitioners who have not opted out.

_____ Member or legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

_____ Member or legal representative acknowledges that they are not currently experiencing an emergency or urgent health care situation.

_____ Member or legal representative acknowledges that a copy of this contract has been made available to him/her.

Member Name:_____ **Date:**_____

Member Signature:_____

(or legal representative or guardian, if applicable)

Jinnah Internal Medicine, LLC

By:_____

Shehzad Jinnah, M.D., Member

JINNAH INTERNAL MEDICINE, LLC

AUTHORIZATION TO SEND TEXT MESSAGES CONTAINING HEALTH INFORMATION

I authorize and direct Jinnah Internal Medicine, LLC, to communicate with me via **unsecured** text messaging for the purpose of sending appointment reminders at _____.
(cellular phone number)

I understand the text messages are unsecure while in transit between Jinnah Internal Medicine and me. Jinnah Internal Medicine does not and cannot ensure the information will not be lost, compromised, or hacked while in transit, and I knowingly accept this risk.

I understand that standard text messaging rates will apply to any messages received from Jinnah Internal Medicine. I also understand that I may revote this permission in writing at any time.

I have reviewed and I understand this Authorization. I also understand that the information communicated pursuant to the Authorization may no longer be protected under federal law if lost, compromised, or hacked in transit. Unless revoked earlier, this Authorization shall remain in effect until my death.

OPT OUT: _____ I do **not** authorize Jinnah Internal Medicine to send me text messages.

Date_____,20_____

_____ **Date of Birth:** _____/_____/_____
(Print Name)

_____
(Signature)

Jinnah Internal Medicine will not condition our provision of services or treatment to you on the receipt of this signed authorization.

JINNAH INTERNAL MEDICINE, LLC
AUTHORIZATION TO EMAIL HEALTH INFORMATION

I authorize and direct Jinnah Internal Medicine, LLC, to send me my medical record including, but not limited to, chart notes, scans, and billing-related information-and other protected health information via **unsecured** email at_____.
(email address)

I understand the email is unsecured while in transit between Jinnah Internal Medicine and me. Jinnah Internal Medicine does not and cannot ensure the information will not be lost, compromised, or hacked in transit, and I knowingly accept this risk.

I have reviewed and I understand this Authorization. I also understand that the information emailed pursuant to this Authorization may no longer be protected under federal law if lost, compromised, or hacked in transit, and I knowingly accept this risk. Unless revoked earlier, this Authorization shall remain in effect until my death.

Date_____,20_____

_____ Date of Birth: _____/_____/_____
(Print Name)

_____
(Signature)

Jinnah Internal Medicine will not condition our provision of services or treatment to you on the receipt of this signed authorization.

For Practice Use Only

We attempted to obtain written authorization to send unencrypted email to patient but could not because:

{ } Patient was informed of and accepted risk orally.
{ } Other:_____

HIPAA PATIENT CONSENT FORM
JINNAH INTERNAL MEDICINE, LLC

2840 Crescent Ave, Suite 500 Eugene, OR 97408

Phone (541) 359-3770 Fax (541) 359_3722

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment' payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of privacy practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revote this Consent in writing at any time and all future disclosure will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The patient acknowledges that he/she has received a copy of our HIPAA practices brochure.

The Consent was given by: _____ _____

(Printed Name) (Signature)

Relationship to Patient
(if other than patient): _____

Witness: _____

Printed Name Practice Representative

PERMISSION TO SHARE MEDICAL IMFORMATION

JINNAH INTERNAL MEDICINE, LLC

2840 Crescent Ave, Suite 500 Eugene, OR 97408
Phone (541) 359-3770 Fax (541) 359-3722

This signed form allows Jinnah Internal Medicine to give information (medical or billing) to the person you list on this form on your behalf. You may remove this authority at any time in writing.

I, _____ _____

Patients Name Patients date of birth

Give permission to share my medical information (ie: labs, radiology, office notes) and financial information (ie billing inquiries, problems) about this visit and all future visits to:

_____

Name (family member or friend) Relationship to patient

I may remove this permission on written notice.

_____

Print patient name

_____

Patient signature

_____

Date

NOTICE OF PRIVACY PRACTICES for
JINNAH INTERNAL MEDICINE, LLC

Revision Date: 02/20/2024

DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Privacy Officer of our office at **541-359-3770.**

WHO WILL FOLLOW THIS NOTICE. This notice describes our practices and that of (1) any healthcare professional authorized to enter information into your medical record that we maintain at this office; and (2) all employees, staff, and other healthcare personnel.

YOUR MEDICAL INFORMATION. We create a record of the care and services you receive at this office. We need this record to provide you with quality service and to comply with certain legal requirements. This notice applies to all of the records about you maintained by this office, Other physicians or healthcare providers that you use may have different policies or notices regarding the use and disclosure of your medical information. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to (1) make sure that medical information that identifies you is kept private: (2) give you this notice of our legal duties and privacy practices with respect to medical information about you; and (3) follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. "Use" is what we do with your information in this office. "Disclose" means sharing your information with others outside this office. All of our permitted uses and disclosures of information fall within one of the categories.

- **For Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses. technicians, office staff, or other personnel who are involved in your care.
- **For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party.
- **For Health Care Operations.** We may use and disclose medical information about you as reasonably necessary. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care.
- **To the Department of Health and Human Services (HHS).** We must disclose your medical information when requested by HHS when it is undertaking a compliance investigation, review. or enforcement action
- **To You.** We must disclose your medical information to you when you request it as described below. We may disclose your medical information to you in other situations.
- **Opportunity to Agree or Object:** We may disclose your medical information in front of others with your informal permission when you are present. If you are not present or otherwise unable to give permission, we may disclose your medical information to others if, in a healthcare provider's professional judgment, disclosure is determined to be in your best interest. This includes telling family or friends involved in your care about your current medical condition.
- **For Appointment Reminders.** We may use medical information about you to remind you about appointments using phone calls, emails, or text messages. This also allows us to leave appointment reminders and messages with limited information on your voicemail and answering machine.
- **Incidental Use.** Although we try to limit communications of your medical information to the minimum necessary. we can disclose information that is incidental to an otherwise permissible use.
- **Valid Authorization.** We may disclose your medical information pursuant to your written authorization. For authorization to be valid, you must sign a form containing certain statements.
- **Public Interest and Benefit Activities.** We may disclose medical information about you for 12 national priority purposes, including when required by law, such as statute or court order: for public health activities, such as providing immunization records to a school with a parent's permission; to government agencies regarding victims of abuse: to health oversight agencies to carry out legally authorized audits and investigations: pursuant to court orders and subpoenas that meet certain requirements: to law enforcement as described below; to a coroner or medical

examiner; as necessary to facilitate organ or tissue donation and transplantation; for research purposes under certain circumstances; to prevent a serious threat to your health and safety or the health and safety of the public or another person; for certain essential government functions; and for workers' compensation or similar programs.

- **Law Enforcement.** We may disclose your health information if asked to do so by a law enforcement official (1) in response to a court order, subpoena, warrant. summons, or similar process; (2) about a death we believe may be the result of criminal conduct; (3) about criminal conduct at the office; or (4) in emergency circumstances, in order to report a crime. the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- **Limited Data Set.** In certain situations we may disclose your medical information within a limited data set for research, healthcare operations, and public health purposes. A limited data set is medical information about you from which certain identifying information about you, your relatives, household members, and employers has been removed.
- **Psychotherapy Notes, Marketing, and Sales of Protected Health Information.** Most uses and disclosures of psychotherapy notes, protected health information for marketing purposes, and that constitute a sale of protected health information require authorization.
- **Other.** Other uses and disclosures not described in this notice will be made only with your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU. You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes prescriptions and billing records. To inspect and copy medical information that may be used to make decisions about you, you may be required to submit your request in writing to the Privacy Officer. 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 medical information, you may request that the denial be reviewed. We will select a licensed healthcare professional to 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 medical information 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 this office. To request an amendment, complete and submit an **AMENDMENT REQUEST** form to the Privacy Officer. 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 (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment: (2) is not part of the medical information kept by or for the office; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper. 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 the time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your

care, like a family member or friend. We are not required to agree to your request unless (1) the disclosure is for the purposes of carrying out payment or healthcare operations, and (2) the protected health information pertains to an item or service which you, or another person other than your health insurance, have paid for in full. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit the REQUEST FOR LIMITATION AND RESTRICTION OF PROTECTED HEALTH INFORMATION to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.

- **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. To request confidential communications, you may complete and submit the PATIENT'S REQUEST TO LIMIT CONFIDENTIAL COMMUNICATIONS to the Privacy Officer. We will not ask you the reason for your request. 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, contact the Privacy Officer.
- **Right to Receive Notice of Breach.** You will receive notification of breaches of your unsecured protected health information unless we determine there is a low probability your PHI was compromised.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office. The summary will contain, in the top right-hand comer the effective date. You are entitled to a copy of the current notice in effect.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact the Privacy Officer. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you

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Print Patients Name Signature