MERRITTHEALTH &WELLNESS

Dear New Patient:

Thank you for choosing Merritt Health and Wellness as your care provider. We look forward to providing care for you. If you prefer this information in a language other than English, please let us know and it can be provided. If you require interpreter services for your appointments, please notify us no sooner than seven calendar days prior to your scheduled appointment.

Enclosed you will find:

DEMOGRAPHIC FORM: name, address, insurance information, etc. Please fill out to the best of your knowledge.

HEALTH HISTORY FORM: knowing as much as possible about your health history will help us tailor your health care as comprehensively as possible.

RELEASE OF RECORDS FORM: if you have records from a previous primary care provider that may be of relevance, prior medical records, or if you would like a future copy of your records from Merritt Health and Wellness, LLC for yourself, please fill out this form. Also, please bring all current medications in original bottles to your first appointment.

POLICY STATEMENT: a summary of Merritt Health and Wellness, LLC clinic policies. Please be sure to read our policies and sign at the bottom.

PRIVACY POLICY: a summary of the Merritt Health and Wellness, LLC privacy policy, including your rights regarding your child's Protected Health Information (PHI) and our responsibilities in safeguarding this information.

Please fill out these forms and bring them with you to your first appointment (to ensure we have all the information ready for your appointment, please arrive 5-10 minutes early).

Feel free to email **ryan@merritthw.com** with any questions.

Seth Merritt, FNP, LMT, CATOM, CLS

Owner, Merritt Health and Wellness, LLC

Merritt Health & Wellness, LLC

Conditions of Treatment

1. **Consent to Treatment**: The undersigned herby consents to the administration and performance of all diagnostic procedures and treatments which, in the judgment of my provider, may be considered necessary or advisable. I understand that treatment may consist of, but is not limited to, telemedicine services (videoconference, telephone) in addition to in-person visits. I give my consent to Merritt Health & Wellness, LLC to audio record, video record, or photograph any interaction as deemed necessary for providing quality healthcare. I understand that these recordings, in part or in whole, may become part of my medical record and may be used for internal purposes, such as quality improvement or education. I understand that telemedicine has its limitations and it does not substitute for the need to see a healthcare provider in person to sufficiently address my health concerns. I further understand that with whomever I establish care as my PCP, written instructions will be provided to me, my family, or my caregiver on whom to contact to follow up or obtain services.
2. **Release of Information**: The clinic will obtain my consent through written authorization to release information, other than basic information, concerning me, except in those circumstances when the clinic is permitted or required to by law release information. I certify that my records may be released to other providers upon request. By signing below, I agree that to the extent necessary to determine liability or payment, and to obtain reimbursement, the clinic may disclose portions of my record, including my medical records to any person or corporation which is or may be liable, for all or any portion of the clinic's charges, including but not limited to insurance companies, health care service plans, or worker's compensation carriers. Special permission is necessary to release this information where I may be treated for alcohol or drug abuse.
3. **Medicare Alignment**: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf.
4. **Assignment of Insurance Benefits**: In the event I am entitled to insurance benefits arising out of any policy insuring me or any party liable to me, I hereby assign said benefits directly to this clinic for application to my bill. I agree that the clinic may issue a receipt for such payment, that such payment shall discharge the insurance company of any and all obligations under the policy to the extent of the payment, and that I shall be responsible for all charges not covered by this agreement.
5. **Financial Agreement**: I hereby agree that I am financially responsible in consideration of services rendered by the clinic, and I shall make prompt payments to the clinic as bills are presented. I accept personal responsibility for all copayment, coinsurance, deductible, and non-covered service amounts as dictated by my, or the patient's, insurance plan. I agree to pay all fees and interest, at the legal rate, should the account become delinquent, and if it becomes necessary for the account to be referred to an attorney or collection agency for collection. I acknowledge that should my account be turned over to an attorney or collection agency for collection, I forfeit my eligibility to continue as a patient of Merritt Health & Wellness, LLC.

I agree to the aforementioned conditions of treatment and understand that I will be required to sign one time, and this will be kept as part of my permanent file.

X_____ _____/_____/_____

Signature of patient, parent, or guardian. Date

Regarding Insurance Coverage for Your Care

To help you understand insurance billing policies please read the following. Knowing these issues up front can save you time, hassle, finances and phone calls. In addition, it allows us to focus on your medical care. Our aim is for your total office experience to be as effective and pleasant as possible.

You will be responsible for visits or procedures that your insurance company denies as "not covered" or "excluded."

We will strive always to do our best to help you but cannot re-bill charges with changed diagnosis codes just to get your insurance to cover. This may be considered fraudulent by insurers and subjects the clinic to audits. Your presenting complaint becomes important in determining whether you are seen and billed correctly. We know many patients are frustrated by the cost of care, but we have no influence over the insurance regulations, their coverage of you and your family, and the payments required for co-pays and deductibles.

We accept most insurance plans (complete list is located on the FAQ page of our website) and as a courtesy we will file your insurance claim for you. However, since there are hundreds of different types of insurance plans, we cannot bend individual charges for each different plan, patient, or visit. We encourage you to familiarize yourself with your own plan prior to scheduling your office visit with us. This includes what services are covered, what prior authorizations or pre-certifications are needed, your deductible, and whether your insurance company will pay for such things as lab work and imaging studies. If your insurance company does not pay as expected, **please call their customer service department directly** as we are unable to guarantee your insurance benefits. We do not handle motor vehicle accident (MVA) claims, even for existing patients.

We request payment for office services at the time of your visit. We accept cash, checks, and most major credit cards and we can bill your health insurance plan for you if you provide us with a copy of your insurance card. Please inform us of any changes to your contact information or insurance coverage. Even if we have been seeing you for a while, we will need to see a copy of your insurance card at every visit. Small details in insurance coverage change from time to time and cards expire…we prefer to get things billed correctly for you the first time.

Bills that are unpaid may be charged a monthly finance charge. **To avoid a $50 charge and let other patient's urgent needs be worked in, please notify us at least 24 hours in advance if you need to cancel or reschedule your appointment.**

Signature:_____ Date: _____/_____/_____

In an effort to provide the best medical services, we have established the following policies.

Your initials below signify your willingness and understanding to comply with these policies.

POLICY STATEMENT: PAYMENT POLICY _____ (Initial)

- You will be required to provide proof of insurance at every visit. In compliance with new Federal law, we will ask you for photo identification and may take your picture at your first office visit.
- It is impossible for our office staff to be aware of each insurance plan's specific requirements or to guarantee coverage by any individual plan. We will do our best to assist you, however it is ultimately your responsibility to verify that we are a member of your PPO or HMO network.
- Your plan may have limitations on the frequency of services performed or where the services may be performed. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements.
- As with any provider's office, any charges you incur at Merritt Health and Wellness, LLC that are not paid or adjusted by your insurance carrier, will be **YOUR** sole responsibility. As a courtesy, we are glad to bill your insurance carrier on your behalf.
- If your deductible hasn't been met for the year, we may require you to pay in full at the time of your office visit. We will then bill your insurance and refund you any claims that are reimbursed.
- We accept cash, checks, and credit/debit card payments. There is a $50.00 fee for returned checks in addition to any fees charged by your financial institution.
- Payment is due within 30 days of receiving your bill. If your outstanding balance is not paid in full within six (6) months, your account will be sent to collections and you will be charged any additional cost of the collections process on top of the balance you owe. Additionally, you will be discharged from our clinic.
- Merritt Health and Wellness, LLC will continue providing care for you while you pay off this balance provided all office visits and other clinic charges acquired from this day forward are paid in full at the time of service.

POLICY STATEMENT: PRESCRIPTION REFILL POLICY _____ (Initial)

- Please allow 3 to 5 business days for all prescription refills. Ask your pharmacy to fax a refill request to the clinic at (866) 309-2838 to expedite the process. If you use a mail order pharmacy, please allow 2 to 3 weeks.

POLICY STATEMENT: RECORDS _____ (Initial)

- We are happy to provide you a copy of your medical records gratis with a signed release of information (ROI) form. However, additional copies will require a charge in accordance with OAR 847-012-000.

POLICY STATEMENT: CHANGES IN DEMOGRAPHIC/INSURANCE INFORMATION _____ (Initial)

- It is your responsibility to advise the clinic of any change in insurance coverage, or changes in name, address, or telephone number.

POLICY STATEMENT: 24-HOUR CANCELLATION/MISSED APPOINTMENT POLICY _____ (Initial)

- Our clinic requires a 24-hour cancellation notice for all appointments because your appointment time is reserved for you. **If you do not show up or give the clinic less than 24-hour notice, you will receive a $50 late cancellation/missed appointment fee. If you violate this policy three (3) times, you may be dismissed as a patient.**
- If you cannot make it to your scheduled appointment, please call (971) 258-1120 to reschedule (you may leave a message after hours). This allows us to give your appointment time to another patient who may need to be seen on that day, and in turn, helps us find time for you when you need to be seen on short notice.
- Unlike most other clinics that double-book office visits, we do not double-book our appointments and reserve office visits 30 to 60 minutes in length. Therefore a 24-hour cancellation notice from you is vital to providing the longer appointments our patients require for comprehensive health care. **There will be a $50 charge for a missed appointment or less than 24-hour cancellation notice.**
- This charge will not be paid by your insurance company.

POLICY STATEMENT: AFTER HOURS URGENT SERVICES (ON-CALL PROVIDERS) _____ (Initial)

- We provide 24/7 on-call coverage. If you have an urgent matter that can't wait until business hours, you may reach an on-call provider by calling the clinic and following the prompts on the outgoing message.
- However, you should be aware that many insurance companies provide 24-hour nursing lines intended for this purpose and therefore may not cover this service.
- This service is not intended for non-urgent matters, scheduling appointments, or prescription refill requests.

POLICY STATEMENT: MOTOR VEHICLE & WORKER'S COMPENSATION CLAIMS _____ (Initial)

- We **DO NOT** accept claims for motor vehicle accidents (MVA's) or worker's compensation claims.
- We will bill any claims for motor vehicle accidents or worker's compensation to your health insurance. If these claims are denied by your health insurance, it will your responsibility to pay whatever amount is not covered.

POLICY STATEMENT: SPECIALTY REFERRAL POLICY _____ (Initial)

- Many private insurances allow patients to self-refer to specialists. We are happy to make recommendations for you.
- We work hard to maintain relationships with specialists. When you fail to show up for a referred appointment we have made for you, it reflects poorly on us and jeopardizes our ability to refer patients to these specialists in the future.
- Therefore, similar to our 24-hour cancellation/missed appointment policy, if you repeatedly fail to show to a referred appointment, you will be dismissed from the practice.

POLICY STATEMENT: ATTENDING TO CHILDREN _____ (Initial)

- We know that it can be difficult to find childcare and we love kids, however the clinic is full of dangerous items and children should not be present during procedures for the sake of everyone's safety.
- Please monitor your children at all times while at the clinic. We will not monitor your children during your office visit.

MERRITTHEALTH &WELLNESS

Name (Preferred):_____ Date: _____/_____/_____

Name (Legal,if different): _____ DOB:_____/_____/_____

Address:_____ Zip:_____

Phone # ( )_____ S.S.#_____ DL#_____

Employer:_____ Work Phone # ( )_____

E-mail:_____ Ht:_____ft._____in. Wt:_____lbs.

Gender Identity: Male Female Trans Male Trans Female Genderqueer/Gender Nonconforming

Sexual Orientation: Straight Lesbian Gay Bisexual/Pansexual/Queer Unknown

Relationship: Single Engaged Married Separated Divorced Widowed Domestic Partner

Ethnicity:_____ Preferred Language:_____

In Case of Emergency, Contact:_____ Phone # ( )_____

IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT, COMPLETE THE FOLLOWING

Name_____ DOB: _____/_____/_____

Address:_____

Phone # ( )_____ S.S.#_____ DL#_____

Employer:_____ Work Phone # ( )_____

E-mail:_____

INSURANCE INFORMATION

Primary Insurance Company:_____ Phone # ( )_____

Claim Address:_____

Policy Holder: _____

ID#_____ DOB:_____/_____/_____ Group #_____ Copay: $_____

Secondary Ins. Comp. (if applicable):_____ Phone # ( )_____

Claim Address_____

Policy Holder _____

ID#_____ DOB:_____/_____/_____ Group #_____ Copay: $_____

I give permission to leave a message (please circle): CELL HOME WORK EMAIL

Signature_____

Why are we seeing you today? _____

Is there currently a lot of stress in your life? YES NO Do you have suicidal thoughts? YES NO

Have you ever been hospitalized for psychiatric issues, or drug or alcohol abuse? YES NO

Are you under the care of a doctor at this time? YES NO

If YES, who and for what? _____

Any medication allergies? _____ Food allergies? _____

Are you currently taking any prescription medications? YES / No (If YES, list names, dosages, and why taken)

DRUG	DOSE	TAKEN FOR WHAT REASON

Are you taking any over-the-counter medications, supplements, or natural remedies? YES NO

If YES, what are they?_____

Please list any diagnosis or illness you may have in the spaces below.

List any <u>Family History</u> of any diseases, illnesses or disorders? Please list in the spaces below.

<u>Surgeries & Hospitalizations:</u> Please list any previous surgeries below:

_____

_____

<u>OB/GYN History (if applicable):</u>

Number of pregnancies:_____ Vaginal delivery or C-section? _____

Gestational Diabetes? YES NO Babies over 9 lbs? YES NO If YES, what was the weight? _____

Menstrual Onset: _____ years old Duration: _____ days Last menstrual period: _____/_____/_____

Do you have pain associated with menstrual cycle? YES NO Are menses heavy? YES NO

Are your menstrual cycles regular? YES NO Do you have pain with sex? YES NO

Birth control method? _____ Taking Hormone Replacement? YES NO

When was your last physical/PAP? _____/_____/_____

Habits:

_____ Never smoked _____ I quit _____ years ago _____ I smoke _____ cigs/day

Do your drink soda or diet soda? YES / NO If YES, how much daily?_____

Do you drink coffee or tea? YES / NO If YES, how much daily?_____

Do you use a sugar substitute? YES / NO If YES, what?_____

Do you drink alcohol? YES / NO If YES, how much daily/weekly?_____

Activity Level (answer only one):

____ Inactive/sedentary – includes only light physical activity associated with typical day-to-day life.

____ Moderate - includes walking 1.5-3 miles per day and light physical activity.

____ Active – includes walking more than 3 miles per day and planned workouts often during the week.

Typical Breakfast	**Snack?**	**Typical Lunch**	**Snack?**	**Typical Dinner**

*Make sure and add any drinks, alcohol, snacks, etc.

SNAG Questionnaire

(Y/N) Do you snore at night?
(Y/N) Stop breathing, choke, gasp during sleep?
(Y/N) Tired, sleepy, fatigued during the day?
(Y/N) Are you overweight?
(Y/N) Are you over 50 yrs old?
(Y/N) Neck circumference greater than 16" (women), 17" (men)?
(Y/N) Do you have high blood pressure or are you on blood pressure medication?

Privacy Policy

This notice describes how medical information about you may be used and disclosed and how you can obtain access to the information.

PLEASE REVIEW CAREFULLY:

OUR RESPONSIBILITY

By law we are required to safeguard your PROTECTED HEALTH INFORMATION (PHI). Your PHI includes data about past, present, future health condition, the services provided to you, and payment for said health care. This notice advises you of your rights and explains when, why, and how we can legally release, transfers, give, or otherwise reveal your PHI to a third party outside our practice. We take these responsibilities seriously and promise to make every effort to execute them in an efficient manner.

YOU HAVE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- Review and receive copies

You may review and/or receive copies of your PHI, such as medical records and billing data. Under certain circumstances, a summary or explanation of your PHI may be more helpful than the actual copies. If you agree, we will provide your health care information in the form you request. The first copy of your records is gratis, however additional copies will be billed as per Oregon Administrative Rule 847-012-000. In limited situations, we may deny some or all of your request. If we do, we will provide our rationale in writing and offer an appeal procedure.

- Request limits to uses and disclosures

You may request a restriction or limitation on your PHI used or disclosed for treatment, payment, or health care operations. You can also request limitation on information disclosed to someone who is involved in your care or the payment for it, such as a family member or a friend. 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 emergency treatment.

- Correct or update

You may request that we correct or add to your medical record if you believe there is a mistake or that important information is missing.

- Request accounting of disclosures

You have the right to ask for disclosures of your PHI.

- Receive confidential communication by alternative means or at a secondary location.

We will accommodate any reasonable request to use alternative means of communication or use a secondary address.

WE MAY USE AND DISCLOSE YOUR HEALTH CARE INFORMATION IN THE FOLLOWING WAYS

- Treatment

We may disclose your PHI to practitioners, office staff or other personnel in our clinic. We may also disclose your health care information to other providers who are involved in taking care of you and your health.

- Health care operations

We may use and disclose your PHI to facilitate efficient operation of our practice and ensure that you receive quality care.

- Payment

We may disclose your PHI to bill and collect payment for the treatment and services we provide.

- Appointment reminders

We may contact you as a reminder that you have an appointment.

- Treatment Alternatives

We may contact you to inform you about possible treatment options that we feel may be of interest to you.

- Health related products and services

We may tell you about health-related products or services that may interest you.

WE MAY ALSO USE YOUR PHI IN SPECIAL SITUATIONS

- To avert a serious threat to health or safety

We may use or disclose your PHI to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- As required by law

We may use or disclose your PHI when required to do so by federal, state or local law.

- Research

We may use and disclose your PHI for research projects that are subject to a special approval process. All research projects are subject to a special approval process that governs patient safety, welfare and the privacy of your medical information. We will ask for your permission if the researcher will have access to your name, address or other information that reveals your identity.

- Organ and tissue donation

If you are an organ donor, we may release PHI to organizations that handle organ procurement as necessary to facilitate such donation and transplantation.

- Military, veterans, national security and intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you.

- Worker's compensation

We may release your PHI to worker's compensation or programs that provide benefits for work related injuries or illness.

- Public health risk

We may disclose your PHI to prevent or control disease, injury or disability. We are also required to report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with specific products.

- Health oversight

We may disclose your PHI to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs and comply with civil rights laws.

- Lawsuits and disputes

We may disclose your PHI in response to law enforcement or a court order, subpoena, warrant, summons, or similar process.

- Coroners, medical examiners and funeral directors

We may release your PHI to determine the cause of death or for other official duties.

- Information not personally identifiable

We may disclose your PHI in a way that does not personally identify you or reveal your identity.

- Family and friends

We may disclose your PHI to your family members or friends if we obtain verbal agreement or if we give you an opportunity to object and you are not capable of giving consent because you are not present or you are incapacitated, we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only information relevant to your care.

- Specific types of PHI

There are more restrictive regulations for use and disclosure of some types of PHI for example, drug and alcohol treatment, HIV, mental health, or genetics testing information.

Even so, there are circumstances in which these types of information may be used or disclosed without your authorization.

- All other uses and disclosures of your PHI require your prior written consent

Except for those uses and disclosers described above, we will not release health care information about you without your written consent.

CHANGES TO THIS NOTICE

We are permitted to change our privacy practices as long as they are consistent with state and federal laws. If we do revise them, we will promptly notify our active patients.

If you have any questions about this notice or if you are concerned that your privacy has been violated please contact us by email ryan@merritthw.com or (971) 258-1120.

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

NOTICE OF PRIVACY POLICY

Effective February 1st, 2012

The following is the privacy policy ("Privacy Policy") of Merritt Health & Wellness, LLC ("Covered "Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent: Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include:

(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required by Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include*: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights with Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right to Request Restrictions on Use or Disclosure. You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures*: to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or

close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right to Receive Confidential Communications You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right to Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health

information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right to Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foresee ably rely, on such information to your detriment. All requests for amendment shall be sent to Seth Merritt, FNP at Merritt Health & Wellness, LLC.

Right to Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes*: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to Seth Merritt at Merritt Health & Wellness, LLC.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer, Seth Merritt at Merritt Health & Wellness, LLC. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to Seth Merritt, FNP at Merritt Health & Wellness, LLC or at the following website address www.merritthw.com.