This is an Agreement entered into on _____ by and between **Salida Clinic, LLC., located at** 920 Rush Drive, Salida, CO, 81201 ("Provider" or "Practice" or "We") and Maria E. Riemann, DNP, APRN, FNP-BC, (Nurse Practitioner) in her capacity as owner of manager of **Salida Clinic, LLC** , and_____ _____("Patient" or "You" or "Them").

Background

The Practice, located at **Salida Clinic, LLC.,** provides ongoing primary care to its patients/members in a direct pay care (DPC) model. In exchange for certain periodic fees, the Practice agrees to provide You with the Services described in this Agreement under the terms and conditions contained in this Agreement.

Agreement

1. Services. In this Agreement, "Services" means the collection of services, medical and non-medical, which are described in Appendix A (attached and incorporated by reference), which We agree to provide to You under the terms and conditions of this Agreement.

2. Patient. In this Agreement, "Patient" "Member" "You" or "Yours" means the persons for whom the Family Nurse Practitioner shall provide care, who have signed this Agreement, and/or whose names appear on the Patient Enrollment Form (attached and incorporated by reference).

3. Term. This Agreement will last for one year, starting on the date on which it is fully executed by the parties.

4. Renewal. The Agreement will automatically renew each year on the anniversary date of the Agreement unless either party cancels the Agreement by giving 30 days written notice of cancellation.

5. Termination. Either party can terminate this Agreement at any time giving 30 days' written notice to the other, of intent to terminate.

6. Payments and Refunds – Amounts and Methods.

(a) In exchange for the Services described in Appendix A, you agree to pay a periodic monthly fee (or Membership Fee) in the amount that appears in Appendix C, which is attached and incorporated by reference;

(b) Thereafter, the Membership Fee shall be due on the first business day of every month.

(c) The Parties agree that the required method of payment shall be by automatic payment through a debit or credit card or automatic bank draft.

7. Early Termination. If You cancel this Agreement before its term ends, we will review and settle Your account as follows:

(A) We will not refund You the unused portion of your fees on a per diem basis;

or

(B) If Fair Market Value of the Services you received over the term of the Agreement exceeds the amount You paid in membership fees before the early termination, You shall reimburse the Practice in an amount equal to the difference between the value of the services received and the amount You paid in membership fees over the term of the Agreement. The Parties agree that the Fair Market Value of the Services is equal to the Practice's usual and customary fee-for-service charges. A copy of these fees is available on request.

8. Non-Participation in Insurance. The Patient understands that the Practice does not Participate in any health insurance, HMO panels, or any other third-party payor health plans, such as Medicare, Medicaid, and CHIPs and has opted out of Medicare. Therefore, neither the Patient nor the Practice may bill or seek reimbursement from any of the above for the Services provided by the Practice under this Agreement. The Practice is prohibited from providing receipts or bills for individual services other than those which are paid for in a fee for service manner.

9. Medicare. The Patient understands that the Practice and staff are opted out of Medicare, Medicaid, and CHIPs so both the Practice and the Patient are prohibited by law from seeking reimbursement from Medicare for any of the Services included and provided under this Agreement. The Patient agrees not to submit bills or attempt to obtain reimbursement from Medicare for any such services. If the Patient is eligible for Medicare, or becomes eligible during the term of this Agreement, s/he will sign the Medicare Private Contract and Agreement as provided by the practice and required by law.

10. This Is Not Health Insurance. Patient acknowledges that the Practice has advised them, and they understand, that this Agreement is not an insurance plan or a substitute for health insurance. It does not replace any health insurance coverage that the Patient may carry. It does not include hospital services, emergency room treatment, or any services not personally provided by the Practice or its staff. This Agreement includes only those Services identified in Exhibit A. If a Service is not specifically listed in Appendix A it is not included under this Agreement. Patient acknowledges that We have advised Them to obtain or continue in full force, health insurance that will cover catastrophic care and healthcare services not included in this Agreement and personally delivered by the Practice.

11. Communications. The Practice endeavors to provide Patients with the convenience of a wide variety of electronic communication options. And although We are careful to comply with patient confidentiality requirements, and make every attempt to protect Your privacy, communications by e-mail, facsimile, video chat, cell phone, texting, and other electronic means, can never be absolutely guaranteed to be secure or confidential methods of communications. By placing your initials at the end of this Clause, You understand and acknowledge the above and You agree that by initiating or participating in the above means of communication, you expressly waive any guarantee of absolute confidentiality with respect to their use. You further understand that participation in the above means of communication is not a condition of membership in this Practice, that you are not required to initial this clause, and that you a have the option to decline any particular means of communication. **____ (Initial)**

12. Email and Text Usage. By providing an e-mail address on the attached Appendix B, the Patient authorizes the Practice and its staff to communicate with him/her by e-mail regarding the Patient's "protected health information" (PHI). By providing a cell phone number in Appendix B and checking the "YES" box on the corresponding consent question, the Patient consents to text message communication containing PHI through the number provided. Patient further acknowledges that:

(A) E-mail and text message are not necessarily secure methods of sending or receiving PHI, and there is always a possibility that a third party may gain access;

(B) Although the Practice and its staff shall make all reasonable efforts to keep e-mail and text communications confidential and secure, We cannot assure or guarantee the absolute confidentiality of these communications;

(C) You also understand and agree that e-mail and text messaging are not appropriate means of communication in an emergency, for dealing with time-sensitive issues, or for disclosing sensitive information. In an emergency or a situation in which could reasonably be expected to develop into an emergency, You understand and agree to call 911 or go to the nearest personnel.

13. Technical Failure. Neither the Practice, nor its staff will be liable for any loss, injury, or expense arising from a delay in responding to Patient when that delay is caused by technical failure. Examples of technical failures: (i) failures caused by an internet or cell phone service provider; (ii) power outages; (iii) failure of electronic messaging software, or e-mail provider; (iv) failure of the Practice's computers or computer network, or faulty telephone or cable data transmission; (iv) any interception of e-mail communications by a third party which is unauthorized by the Practice; or (v) Patient's failure to comply with the guidelines for use of e-mail or text messaging, as described in this Agreement.

14. Nurse Practitioner Absence. From time to time, due to conferences, vacations, illness, or personal emergency, etc., the Nurse Practitioner may be temporarily unavailable. When the date/s of such absences are known in advance, the Practice shall give notice to Patients so that they may schedule non-urgent care accordingly. During unexpected absences, Patients with scheduled appointments shall be notified as soon as practicable, and appointments shall be rescheduled at the Patient's convenience. If, during Physician absence, Patient should experience an acute medical issue requiring immediate attention, Patient should proceed to an urgent care or other suitable facility for care. Charges from Urgent Care and any other outside provider are not included under this Agreement and are the Patient's responsibility. However, Patient may submit such charges to Patient's insurance or request that the outside provider do the same. We cannot guarantee insurance reimbursement.

15. Dispute Resolution. Each Party agrees not to make any inaccurate or untrue and disparaging statements, oral, written, or electronic, about the other. We strive to deliver only the best of personalized patient care to every Member, but occasionally misunderstandings arise. We welcome sincere and open dialogue with our Members, especially if we fail to meet expectations, and We are committed to resolving all Patient concerns. Therefore, in the event that a Member is dissatisfied with, or has concerns about, any staff member, service, treatment, or experience arising from their membership in this Practice, the Member and the Practice agree to refrain from making, posting or causing to be posted on the internet or

any social media, any untrue, unconfirmed, inaccurate, disparaging comments about the other. Rather, the Parties agree to engage in the following process:

A. Member shall first discuss any complaints, concerns, or issues with **Salida Clinic, LLC**.;

B. **Salida Clinic, LLC.** shall respond to each of Member's issues and complaints;

C. If, after such response, Member remains dissatisfied, the Parties shall enter into discussion and attempt to reach a mutually acceptable solution.

16. Monthly Fee and Service Offering Adjustments. In the event that the Practice finds it necessary to increase or adjust monthly fees or Service offerings before the termination of the Agreement, Practice shall give Patients 30 days' written notice of any adjustment and if Patient does not consent to the modification, Patient shall terminate the Agreement in writing prior to the next scheduled monthly payment.

17. Change of Law. If there is a change of any relevant law, regulation or rule, federal, state or local, which affects the terms of this Agreement, the parties agree to amend this Agreement to comply with the law.

18. Severability. If any part of this Agreement is considered legally invalid or unenforceable by a court of competent jurisdiction, that part will be amended to the extent necessary to be enforceable, and the remainder of the Agreement will stay in force as originally written.

19. Amendment. Except as provided within, no amendment of this Agreement shall be binding on a party unless it is in writing and signed by all the parties.

20. Assignment. Neither this Agreement, nor and any rights arising under it, may be assigned or transferred without Agreement of the Parties.

21. Legal Significance. You acknowledge that this Agreement is a legal document and gives the parties certain rights and responsibilities. You also acknowledge that You are suffering no medical emergency. You have had a reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and are satisfied with the terms and conditions of the Agreement.

22. Miscellaneous. This Agreement shall be construed without regard to any rules requiring that it be construed against the party who drafted the Agreement. The captions in this Agreement are only for the sake of convenience and have no legal meaning.

23. Entire Agreement. This Agreement contains the entire Agreement between the parties and replaces any earlier understandings and agreements whether they are written or oral.

24. No Waiver. Any Party may choose to delay or not to enforce a right or duty under this Agreement. Doing so shall not constitute a waiver of that duty or responsibility and the Party shall retain the absolute right to enforce such rights or duties at any time in the future.

25. Jurisdiction. This Agreement shall be governed and construed under the laws of the State of Colorado. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the Practice in Salida, Colorado.

26. Notice. Notices as required under Paragraph 13 above may be achieved either through electronic means at the email address provided by the Party to be noticed or through first class US Mail. All other required notice must be delivered by first class U.S. mail to the Practice, at the address written above and to Patient, to at the address appearing in Appendix B.

The Parties may have signed duplicate counterparts of this Agreement on the date first written above.

Salida Clinic, LLC.,

_____ _____

By: Maria E. Riemann, DNP, APRN, FNP-BC Date _____

Patient:

_____ _____

Signature of Patient Date

APPENDIX A

SERVICES

1. Medical Services. Medical Services under this Agreement are those medical services that the Family Nurse Practitioner permitted to perform under the laws of the State of Colorado, and are consistent with Family Nurse Practitioner's training and experience. The Patient is responsible for all costs associated with any medications, laboratory testing, and specimen analysis associated with these Services which are not personally provided in-house, by the Practice staff.*

The Medical Services provided under this Agreement include the following:

- Preventive medicine
- Office visits

- Well exam
- Women Wellness Exam*
- Acute visit
- Sports physical
- Chronic care
- Simple Suturing
- Non-complicated incision and drainage
- Non-complicated laceration repair
- Ear wax removal
- Skin tag removal
- Office strep screen
- Office urinalysis
- Office glucose
- Lesion Removal*
- Cryotherapy skin lesion

*Patient is responsible for all costs associated with any, laboratory testing, specimen analysis, pathology, or other services which are not personally provided by the Practice staff and/or are not performed on-premises (e.g., labs and biopsies which must be sent out for analysis, medications, etc.).

2. Non-Medical, Personalized Services. The Practice shall also provide Patient with the following non-medical services, which are complementary to our members in the course of care:

• Same Day/Next Day Appointments. Subject to the limitations of paragraph 13, above, Patients who contact the Practice before 10am on a regular office day, Patient may be scheduled for a same or next day appointment when desired and appropriate.

• No Wait or Minimal Wait Appointments. All reasonable effort shall be made to assure that Patient is seen by the Nurse Practitioner immediately upon arriving for a scheduled office visit or after only a minimal wait. If the Nurse Practitioner foresees a minimal wait time, Patient shall be contacted and advised of the projected wait time. Patient shall have the option to arrive

at the new, later time or reschedule at a date convenient for Patient.

• After Hours Access. Subject to the limitations of paragraph 13 above, Patient shall have direct telephone access to their nurse practitioner for guidance in regard to urgent concerns that arise unexpectedly after office hours. Text messaging may be used when the Nurse Practitioner and Patient agree that it is appropriate.

• E-Mail Access. The Patient shall be given the Nurse Practitioner's e-mail address to which non-urgent communications can be addressed. Patient understands and agrees that email and the internet should never be used to access medical care in the event of an emergency or any situation that could reasonably develop into an emergency. Patient agrees that in this situation, when s/he cannot speak to the Nurse Practitioner immediately in person or by telephone, to call 911 or go to the nearest emergency medical assistance provider, and follow the directions of emergency medical personnel.

• Patient Care Coordination. Nurse Practitioner shall assist in Patient referrals for specialty care and coordinate with Patient's specialty providers to assure continuity of care as appropriate. Patient understands that fees paid under this Agreement do not include fees due to such specialty physicians or any medical professional other than the Practice Nurse Practitioner.

APPENDIX B

PATIENT ENROLLMENT FORM

The fees as set out in the attached appendix C, shall apply to the following patient(s), who by signing below (or as parent or legal guardian), certify that they have read and agree to the terms and conditions of this Agreement.

Check yes where indicated only if you agree to text message communication and provide email address only if you agree to email communication. Your signature indicates acceptance of the terms of the patient agreement.

PATIENT 1

PATIENT NAME_____ DOB_____

STREET

ADDRESS_____

CITY, STATE, ZIP_____

PREFERRED PHONE CONTACT # _____ CELL PHONE_____

EMAIL_____

I AGREE TO TEXT COMMUNICATION: (CHECK ONE BELOW)

 YES

 NO

SIGNATURE:

_____

RELATIONSHIP TO PATIENT:

_____

PATIENT 2

PATIENT NAME_____ DOB_____

STREET ADDRESS_____

CITY, STATE, ZIP_____

PREFERRED PHONE CONTACT # _____ CELL PHONE_____

EMAIL_____

I AGREE TO TEXT COMMUNICATION: (CHECK ONE BELOW)

 YES

 NO

SIGNATURE:

_____

RELATIONSHIP TO PATIENT:

_____

PATIENT 3

PATIENT NAME_____DOB_____

STREETADDRESS_____

CITY, STATE, ZIP_____

PREFERRED PHONE CONTACT _____ CELL PHONE_____

EMAIL_____

I AGREE TO TEXT COMMUNICATION: (CHECK ONE)

 YES

 NO

SIGNATURE:

_____

RELATIONSHIP TO PATIENT:

_____

PATIENT 4

PATIENT NAME_____ DOB_____

STREETADDRESS_____

CITY, STATE, ZIP_____

PREFERRED PHONE CONTACT _____ CELL PHONE_____

EMAIL_____

I AGREE TO TEXT COMMUNICATION: (CHECK ONE)

 YES

 NO

SIGNATURE:

_____

RELATIONSHIP TO PATIENT:

_____

APPENDIX C
FEE ITEMIZATION

No Re-enrollment fee.

Patient shall be accepted back into the Practice, if desires, after allowing membership to lapse or be terminated on a space available basis, and will not be subject to any enrollment fee.

Monthly Membership Fees

Ages 0-18 years ____ @ $35 per month $ _____

Ages 19-45 years _____ @ $75 per month $ _____

Ages 46-65 years _____ @ $100 per month $ _____

Ages 66 years + _____ @ $120 per month $ _____

Total Monthly Membership Fee $ _____

Initial Payment

Enrollment Fees $ 75 (per adult enrollment)

Total Due on Signing $ _____

APPENDIX D

AUTOMATIC CREDIT/DEBIT CARD BILLING AUTHORIZATION

To enjoy the convenience of automated billing, simply complete the Credit/Debit Card information section below and sign the form. All requested information is required. Upon approval, you will have the option to make monthly payments or set up a monthly auto-deduction. Payments are made directly through our secure link accessed through your electronic

statement sent to your email. Your statement will include monthly fees and incidental charges which you will receive prior to any payments or deductions.

Customer(s)Name(s):_____

PAYMENT INFORMATION

I authorize **Salida Clinic, LLC.,** to automatically bill the card listed below as specified: Amount: $_____ for monthly subscription and Incidental Charges;

Frequency:

Monthly Start billing on: ____/____/____

End billing when: Customer provides written cancellation

CREDIT/DEBIT CARD INFORMATION:

Credit card type: **[ ]** Visa, **[ ]** MasterCard, **[ ]** American Express, **[ ]** Discover

_____ _____ _____/_____

Credit card number: Expires:

_____ _____

Cardholder's name: As shown on credit card CVC(Security code)

_____ _____

Customer's signature Date:

APPENDIX E

ACH AUTHORIZATION

I, _____, hereinafter called PATIENT, hereby authorize **Salida Clinic, LLC.,** hereinafter called PROVIDER, to initiate debits and/or credits to or from my Bank Account indicated at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit and or credit the same to such account. We acknowledge that

the origination of ACH transactions to or from our account must comply with the provisions of U.S. law.

Please provide this originator number to your bank account so that we can successfully process the ACH: ORIGINATOR # _____

PATIENT'S Bank:

_____

City: _____State: _____Zip:_____

Routing Number: _____

Account Number: Account Type: ☐ CHECKING ☐ SAVINGS

This authorization is to remain in full force and effect until **Salida Clinic, LLC.,** has received written notification from the Company of its termination in such time and such manners as to afford **Salida Clinic, LLC.,** a reasonable opportunity to act on it.

_____

PRINT AUTHORIZATION BY INDIVIDUAL TO SIGN/ACT ON BEHALF OF THE PATIENT

_____

SIGNATURE

Date: _____

_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GAIN ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

A. OUR COMMITMENT TO YOUR PRIVACY:

Salida Clinic, LLC., (the Practice), is dedicated to maintaining the privacy of your personally identifiable, protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We strive to maintain the confidentiality of health information that identifies you. This notice explains the privacy practices that we maintain concerning your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by the 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. You may request a copy of our most current notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Salida Clinic, LLC.,

Attn: Privacy Officer

124 North C Street, Salida, CO 81201

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, unless you object:

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. Our staff may use or disclose your PHI in order to treat your or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as other healthcare providers, your spouse, your children or your parents.

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. We do not accept or bill insurance, so we do not disclose your information for the purpose of being reimbursed by insurance. However, we may

use and disclose your PHI to obtain payment from those that may be responsible for such costs, such as family members.

3. Health Care Operations. The 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, to develop protocols and clinical guidelines, to develop training programs, and to aid in credentialing, medical review, legal services and insurance.

4. Appointment Reminders. The Practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Release of Information to Family/Friends. The Practice may release your PHI when necessary, to a friend or family member that is involved in your care. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

6. Disclosures Required by Law. The Practice will use and disclose your PHI when we are required to do so by federal, state, or local law or regulation.

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 PHI: When required by law to collect information for the purpose of:

1. Health Oversight Activities. The 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.

2. Lawsuits and Similar Proceedings. The 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.

3. Law Enforcement. We may release PHI if required 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)

4. Deceased Patients. The 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 may also release information in order for funeral directors to perform their jobs.

5. Organ and Tissue Donation. The 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.

6. Serious Threats to Health or Safety. The 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.

7. Military. The 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.

8. Workers' Compensation. The Practice may release your PHI if required for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI:

The health and billing records we maintain are the physical property of Practice. The information in it, however, belongs to you. You have a right to:

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 the Privacy Officer,
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. Your request must describe in a clear and concise fashion:
(a) the information you wish restricted;
(b) whether you are requesting to limit our Practice's use, disclosure or
both; and
(c) 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 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. 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 is not available to amend the information.

5. Paper Copy of this Notice. You may 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.

6. Filing a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our Practice. To file a complaint with our Practice, contact our privacy officer at the address provided above. All complaints must be submitted in writing and you will not be penalized for filing a complaint.

7. 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. You have the right, at any time, to revoke your authorization to disclose your PHI. Simply send a written notice of revocation to the Privacy Officer at the address provided above. 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 questions regarding this notice or our health information privacy policies, please contact the Privacy Officer listed above.

Acknowledgement

I hereby acknowledge that I have received and read this Notice of Privacy Practices. I understand that I may request additional copies of this notice at any time.

_____ _____

Patient Name Date