HIPAA Notice of Privacy Practices & Policies
Arches Primary Care, LLC

This notice outlines your protected health information (PHI), how it may be used, and what your rights are. Please review carefully and ask any questions you have, prior to signing it. Please direct all questions to Marivic Vanover, APN-C, email: jed@archesprimarycare.com.

We, *Arches Primary Care, LLC* understand that PHI about you and your health is very personal. We are committed to protecting your PHI. This notice applies to ALL of the records of your care/coaching generated by *Arches Primary Care, LLC* and our personnel. This notice will explain the ways in which we could use and disclose PHI about you. We also describe your rights and certain obligations we have regarding the use and disclosure of PHI. The law requires us to:

*make sure that your PHI that identifies you is kept private
*notify you about how we protect your PHI
*explain how, when, & why we use and disclose PHI
*follow the terms of the notice that is currently in effect

We are required to follow the procedures in this notice. We reserve the right to change the terms of this notice and to make new notice provisions effective for all PHI that we maintain by:

*providing copies of this notice upon registration as a client of *Arches* Primary Care, *LLC.*
*providing copies of this notice upon request
*posting a copy of this notice on our Facebook page or website.

How we may use and disclose protected health information about you:

The following categories describe different ways that we use and disclose PHI without your written authorization.

For TREATMENT & Continuity of Care: We may use PHI about you to provide you with, coordinate, or manage your medical or health treatments or associated services. We may disclose PHI about you to health care providers, or other health care team members that are involved in providing your health care. *Arches Primary Care, LLC* may also share PHI in order to coordinate the different parts of your treatment plan you need, such as pharmaceuticals, lab work, and x-rays; this provision of care may also extend to providers outside *Arches Primary Care, LLC* staff as it relates to your health care and continuity of such care.

For PAYMENT: *Arches Primary Care, LLC* may disclose certain health information to others for billing, invoicing, and/or receiving payment for services you receive from *Arches Primary Care, LLC*. Only the minimal information required by such third party will be disclosed.

As required by Law: *Arches Primary Care, LLC* may disclose your health information as required by law as in cases pursuant to legal authority, to report information as related to victims of abuse, neglect or domestic violence, and/or to assist law enforcement officials in standard law enforcement duties.

For Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury or disability or for other health oversight activities.

Your Written Authorization is REQUIRED for other uses & disclosures

Including:

Uses & disclosures for PHI for marketing purposes; and
Disclosures that constitute a sale of your PHI.

Your PHI Rights:

You have the right:

- to request restrictions to certain uses & disclosures of your PHI; however, *Arches Primary Care, LLC* may not be required to agree to such requested restrictions.
- Obtain a paper copy of this Notice of Privacy Practices upon request
- Inspect and obtain a copy of your health record as provided for under the law
- Amend your health record, according to law, by submitting a written request
- Request communications of your PHI by alternative means, (i.e. email, fax, etc)
- Receive an accounting of disclosures made of your PHI
- Request an electronic copy of your record be provided to you.

Obligations of *Arches Primary Care, LLC*

Arches Primary Care, LLC is required by law to:

- Maintain the privacy of PHI and notify you in the event of a breach, if the breach poses significant risk to you
- Provide you with THIS notice of our legal duties & privacy practices with respect to your PHI
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction on how your information is used
- Accommodate reasonable requests you make to communicate PHI by alternative means
- Obtain your written consent to use or disclose your PHI for any reason other than listed herein

Complaints & Information

You may submit any written complaints regarding potential breaches in privacy or requests for further information by contacting *Arches Primary Care, LLC*. Email: jed@archesprimarycare.com.

Arches Primary Care, LLC reserves the right to change its information practices & to make new provisions effective for all PHI that we maintain. Revised notices will be made available on our Facebook page and/or website.

By printing and signing my FULL name below, I acknowledge that I have received and read a copy of this Privacy Notice from Arches Primary Care, LLC.

Signature _____ Today's date_____

PRINT full name BELOW:

_____ Date of birth_____

CONSENT TO VIDEO CHAT

By signing below, I hereby consent to the use of a video chat for my medical visit via a video conference call. Due to the President's Emergency Declaration, I understand the media, link, or software used for this video visit may not be fully HIPAA compliant. I understand that *Arches Primary Care, LLC* AND Marivic Vanover, APN-C will take all appropriate and available actions to help keep these visits safe and secure. I release *Arches Primary Care, LLC* AND Marivic Vanover, APN-C from any and all liability and responsibility associated with any possible and accidental release of personal health information.

Signature _____ Today's date_____

INFORMED CONSENT

By signing below, I hereby consent to health care management and treatment by Marivic Vanover, APN-C AND *Arches Primary Care, LLC*. I acknowledge that it is my responsibility as a patient to seek out information needed regarding my diagnosis, management, treatment plan, and medications. I agree to be a partner in my health care and in decisions related to my care.

Signature _____ Today's date_____