Notice of Privacy Practices

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

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law (the Health Insurance Portability and Accountability Act of 1996 or HIPAA) to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI, By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights concerning your PHI
- Our obligation concerning the use and disclosure of your PHI

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

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

Privacy Officer: 37000 Grand River Ave, Suite 310 Farmington Hills, 48335 Phone: (248) 536-2127

C. Uses and Disclosures of Health Information

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, medical students, or other health care providers who are involved in taking care of you now or in the future.

We may also use health information about you to call you or send you a letter to remind you about an appointment, to follow up with diagnostic tests results, or to provide you with information about other treatment and care that could benefit your health.

For payment: We may use and disclose medical information about you so that the treatment and services you receive at the hospital may be billed and payment may be collected from you, an insurance company or a third party.

For healthcare operations: Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. Every effort will be made to insure anonymity.

D. Other Disclosures

Business Associates: We will share your PHI with third party associates that perform various activities for the clinic. Whenever any arrangement between our clinic and a business associate involves the use of disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Communication with others involved with your care: Our health professionals may, in the event you are incapacitated or in an emergency circumstance, using their judgment, disclose to a family member, or other relative, close personal friend or any other person you identify, health information directly relevant to that person's involvement in your care or payment related to your care.

Research: Under certain circumstances, we may use and disclose health information about you from your medical record for research purposes. All research projects, however, are subject to a special approval process designed to protect the privacy of your health information.

Required by law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such disclosures,

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

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect

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

Health Oversight Activities: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Legal Proceedings: We may disclose your PHI In the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, in certain conditions in response to a subpoena, discovery request or other lawful purpose.

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

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

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

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

Research: Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your PHI is being used only for the research and (iii) the researcher will not remove any of your PHI from our practice; or (c) the PHI sought by the researcher only relates to decedents and the researcher agrees in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the PHI of the decedents.

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

Military: Our practice may disclose your PHI if you are a member of the U.S. Armed Forces, a veteran, or a member of foreign military forces for activities deemed necessary by appropriate military commend authorities, including the Department of Veteran's Affairs for the purpose of your eligibility for or entitlement to certain benefits provided by law.

National Security: Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

Inmates: Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you (b) for the health, safety and security of the institution, and its officers and employees and/or (c) to protect your health and safety or the health and safety of other individuals.

Worker's Compensation: Our practice may release your PHI for worker's compensation and similar programs to the extent necessary to comply with applicable laws.

Required Uses and Disclosures: Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirement of Section 164.500 et. seq. We will not use information in your records for marketing purposes.

Other uses and disclosures from your medical record will be made only with your written authorization or approval.

IEP HEALTHY URGENT CARE

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

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, please use the contact information below to make an appointment to complete the form. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

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 using the contact information below. 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;
(c) and 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. However, you may not obtain psychotherapy notes or information compiled in reasonable anticipation of a civil, criminal or administrative action or proceeding. You must submit your request in writing using the contact information below 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 our practice. To request an amendment, your request and reason for the request must be made in writing using the contact information below. 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) was not created by our practice, unless the individual or entity that created the information is not available to amend the information.

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

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices.
7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint with our practice, use the contact information below.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization.
Please note: We are required to retain records of your care.
Contact Information: 37000 Grand River Ave, Suite 310 Farmington Hills, 48335 Phone: (248) 536-2127

Signature of Patient/Guardian _____ **Date:** _____

Witness _____ **Date:** _____

IEP HEALTHY URGENT CARE

GENERAL CONSENT FOR TREATMENT

1. I authorize Healthy Urgent Care to provide medical services that are advised to me by the physician. These include all routine diagnostic and laboratory tests (procedures). I authorize any routine medication and medical care that will be provided to me. These include routine diagnostic, radiology and laboratory procedures, routine therapeutic procedures, routine medical care and routine medications. I understand that in an emergency it may be necessary (advisable) to deviate from the routine medical care provided in order to preserve my life (health). I consent to these expanded services and procedures. I authorize any procedure that will be performed and I understand the risks of those procedures I understand that all procedures will be explained to be in detail. I understand that in the case of an emergency I will be transported to an emergency room by an ambulance. I understand the full general consent for treatment form and I will give consent for treatment.

2. I acknowledge that the proposed procedure, the potential risks and benefits, and the possible complications of such procedure have been explained to me as well as the possible risks and benefits of not undergoing this procedure. I further acknowledge that alternative methods of available treatment were discussed with me, and that I was given adequate opportunity to ask questions pertaining to this procedure and the alternative methods. No guarantee or assurance has been given by anyone as to the results that may be obtained from this procedure.

3. I authorize Healthy urgent care to perform laboratory tests that may require specimens of blood, urine and other bodily (fluids, tissues) that are withdrawn from me for diagnostic purposes. I authorize Healthy Urgent Care to dispose of these specimens.

4. I understand that it is my responsibility to take care of my personal belongings, including valuables (money, credit cards etc...). Healthy Urgent Care is not responsible for any lost or damaged personal belongings.

5. I authorize Healthy Urgent Care to release all information from my entire medical record. This includes information about (HIV) human immunodeficiency Virus, (AIDS) acquired immunodeficiency syndrome; psychological and social services information and substance abuse information protected by 42 code of federal regulations part 2. I authorize the release of my medical record to any third-party payer or insurance company. Including but not limited to Medicare, Medicaid, Maternal and infant health, Blue Cross/Blue Shield, automobile no-fault insurers, worker's disability compensation insurers, commercial health insurers, health maintenance organizations, managed care plans and preferred provider organizations. The third-party payer or insurance company or any other entity that is (are) responsible for in part or whole for paying my medical charge (bill) for services provided by Healthy Urgent Care. I authorize Healthy Urgent Care to release all information from my entire medical record for any health care facility or physician to which I am transferred or referred for continuity of care or for an emergency. I understand that Information will be provided in writing to the Hospital (physician) that I am referred (transferred) to. I authorize Healthy Urgent Care to release all information from my entire medical record to my primary care physician for continuity of care and to any independent auditors or reviewer retained by any third-party payer, private health insurer or any employer providing health insurance benefits to me. I understand that this may be necessary for reviewing or auditing Healthy Urgent Care charges for services provided. I understand that Healthy Urgent Care may also use information in my medical record for review (quality control) performed by Healthy Urgent Care.

6. IEP PC Urgent Care, PLLC has made no assurances or guarantees about the results of my office visit at Healthy Urgent Care. I understand that all patients will receive medical treatment performed by Healthy Urgent Care Physicians, Physicians Assistants or Nurse Practioner's: based on the standard of care for outpatient Urgent Care treatment in the community and that no contract (written or implied) is made with Healthy Urgent Care or any Healthy Urgent Care Staff (Medical Providers or any other staff).

7. Discharge Acknowledgment and Patient Portal: You agree and understand that the Healthy Urgent Care Staff has provided you with discharge instructions at the time of visit and that the staff has instructed you that all medical records and discharge instructions are available on a patient portal that you will need to sign up for. Paper instructions are available upon request.

Patient Signature: **Witness Signature:**

_____ _____

Signature of Informant:

_____

Relationship to patient: _____ **Age of Person Consenting:** _____

IEP HEALTHY URGENT CARE

Payment Policy

Thank you for choosing us as your urgent care provider. We are committed to providing you with quality and affordable health care. Because some our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan we participate in, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services.** Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance.** All patients must complete our patient information form before examination. We must obtain a copy of your driver's license and proof of current valid insurance information. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for payment of the entire claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that any balance is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 30 days past due, you may receive a statement indicating that you have 15 days to pay your account in full. Failure to pay will result in your outstanding balance being charged a monthly time-price differential at the rate of 1.5 % per month. Partial payments will not be accepted unless agreed to in writing. We reserve the right to refer your account to a collection agency. In the event that we are required to initiate collection action; you will be additionally responsible for payment of any court costs and attorney fees. Any account payment made with a dishonored check will incur a charge of $35.00.

Thank you for understanding our payment policy. Please let us know if you have questions or concerns.
I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party: _____ **Date:** _____

By Checking this Box I acknowledge and Agree to the Policies and Procedures Outlined in this Document ☐

Signature of Witness: _____