Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION (PHI) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. YOU MAY HAVE ADDITIONAL RIGHTS UNDER STATE AND LOCAL LAW. PLEASE SEEK LEGAL COUNSEL FROM AN ATTORNEY LICENSED IN YOUR STATE IF YOU HAVE QUESTIONS REGARDING YOUR RIGHTS TO HEALTH CARE INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices ("Notice") apply to Evolutionary Services and Consulting (ESC) its affiliates, and its employees. ESC will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patient's protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by ESC. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA").

. MY PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to: • Make sure that PHI that identifies you is kept private. • Give you this notice of my legal duties and privacy practices with respect to health information. • Follow the terms of the notice that is currently in effect. • I can change the terms of this Notice, and such changes will apply to all the information I have about you. The new Notice will be available upon request, in my office, and on my website

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on October 1, 2023.

100 N Howard St, Ste
W Spokane, WA 99201
623-281-8777
lekeshia@evolutionaryservice.com
evolutionaryservice.com

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE
Under HIPPA, you have certain rights regarding the use and disclosure of your protected health information (PHI).

HOW WE COLLECT INFORMATION ABOUT YOU
ESC and its employees and volunteers collect data through a variety of means including but not necessarily limited to company documentation, letters, phone calls, emails, voicemails, and from the submission of applications that are either required by law or necessary to process applications or other requests for assistance through our company.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION AUTHORIZATION AND CONSENT
Except as outlined below, we will not use or disclose your protected health information for any purpose other than services, payment, or healthcare operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Services: We will make use and disclosure of your protected health information as necessary for your services. Professionals involved in your care will use information in your record and information that you provide about your symptoms and reactions to the services provided, which may include procedures, psychoeducation, etc.

Uses and Disclosures for Payment: We will make use and disclosure of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your services to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our healthcare operations, which may include clinical improvement, professional peer review, business management, accreditation, licensing, etc. For instance, we may use and disclose your protected health information for purposes of audits from the state.

Involved In Your Care: We may from time to time disclose your protected health information to designated family, friends, and others who are involved in your care or in payment of your care to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a

limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as insurance companies for auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request, and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such a request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Owner at the address below.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law.
- Public health activities such as required reporting of immunizations, disease, injury, birth, and death, or in connection with public health investigations.
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or immediate danger.
- To your employer when we have provided services to you at the request of your employer.
- To a government oversight agency conducting audits, investigations, civil or criminal proceedings.
- The court or administrative-ordered subpoena or discovery request.
- To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- If you are a member of the military, we may also release your protected health information for national security or intelligence activities.
- To workers' compensation agencies for workers' compensation benefit determination.

DISCLOSURES REQUIRING AUTHORIZATION

Notes: We must obtain your specific written authorization prior to disclosing any notes, unless otherwise permitted by law. However, there are certain purposes for which we may disclose notes, without obtaining your written authorization, including the following:

(1) To carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you),
(2) To the Department of Health and Services to determine our compliance with the law
(3) As required by law,
(4) For clinical oversight activities authorized by law.
(5) For the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.
(6) For use is defending myself in legal proceedings instituted by you.

Genetic Information: We must obtain your specific written authorization prior to using or disclosing your genetic information for services, payment, or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child (if applicable), without your written authorization only where it would be permitted by law.

Marketing: We must obtain your authorization for any use or disclosure of your protected health information for marketing.

CERTAIN USES AND DISCLOSURES REQAUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT

Disclosures to family, friends, or others: You have the right and choice to tell me that I may provide your PHI to a family member, friend, or other person whom you indicate is involved in your care or the payment for your health care, or to share your information in a disaster relief situation. The opportunity to consent may be obtained retroactively in emergency situations to mitigate a serious and immediate threat to health or safety or if you are unconscious.

WHAT WE DO NOT DO WITH YOUR INFORMATION

Information about your behavioral health conditions, medical conditions, care, and financial situation that you provide to us in writing, via email, on the phone (including information left on voicemails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence. We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or patients who apply for or receive our services that are considered patient confidential, restricted by law, or specifically restricted by a patient in a signed HIPAA consent form.

RIGHTS THAT YOU HAVE REGARDING YOUR PHI

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the owner, LeKeshia Mathis. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies, you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the owner, LeKeshia Mathis.

Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the owner, LeKeshia Mathis. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for services, payment, or health care operations. We are not required to agree to most restriction requests but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid Evolutionary Services and Consulting in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected

health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Owner at the address below.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources:
Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of ECS. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without the client's written advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct and written consent.

Revoke an Authorization: You have the right to revoke an authorization.

Communication: You have the right to Opt out of communications from our organization.

Complaints: If you believe your privacy rights have been violated, you can file a complaint by contacting me using the information provided below or by filing a complaint with the HHS Office for Civil Rights located at 200 Independence Avenue, S.W., Washington D.C. 20201, calling HHS at (877) 696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints. I will not retaliate against you for filing a complaint.

The Right to Choose Someone to Act For You: If you have given someone medical power of attorney or if someone is your legal guardian, that person can make choices about your health information

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the Owner of Evolutionary Services and Consulting by phone at 623-281-8777, email: lekeshia@evolutionaryservice.com, or at the following address: 100 N. Howard St. Suite W Spokane, WA 99201.

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CHANGES TO THIS NOTICE

I can change the terms of this Notice, and such changes will apply to all the information I have about you. The new Notice will be available upon request, in my office and on my website.

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