Dr. Dianna Carvey, D.O.

DIRECT PRIMARY CARE PATIENT AGREEMENT

This is an Agreement entered into on _____________________ , 20_____, between Eureka Family Health and Wellness, PLLC, a Montana Professional Limited Liability Company, ("**the Practice**"), and ________________________________("**You**" or "**Patient**"), residing at ___________________________________ ____.

Background

Dianna M Carvey. D.O. (**"Provider"**) practices primary healthcare and delivers care on behalf of the Practice. The Practice is a Direct Primary Care Practice, which delivers primary care services at 239 Front, Building A, Eureka, MT 59917. The Provider also operates as EUREKA FAMILY HEALTH AND WELLNESS DPC, and as EUREKA FAMILY HEALTH AND WELLNESS DIRECT PRIMARY CARE.

In exchange for certain fees, the Practice agrees to provide You with Services described in this Agreement according to the terms and conditions contained in this Agreement.

Definitions

A. **Patient**. In this Agreement, "Patient" means the persons for whom the Provider shall provide care, and who have signed this agreement or are listed on the document attached as Appendix A, which is a part of this Agreement.

B. **Services**. In this Agreement, "Services" means the collection of services, offered to you by us in this Agreement. These Services are listed in Appendix A, which is attached and a part of this agreement.

C. **Fees**. In this Agreement, "Fees" means the enrollment and membership fees identified in Appendix B to this Agreement.

Agreement

NOTICE

1. THIS MEDICAL RETAINER AGREEMENT DOES NOT CONSTITUTE INSURANCE AND IS NOT A MEDICAL PLAN THAT PROVIDES HEALTH INSURANCE COVERAGE FOR THE PURPOSES OF THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT. THIS AGREEMENT COVERS ONLY LIMITED, ROUTINE HEALTH CARE SERVICES AS DEFINED AND LISTED IN THIS AGREEMENT. **Patient Initals: __________**.

2. **TERM**. This Agreement will be on a month to month basis starting on ______________, 20___.

3. **PAYMENTS | Amounts and Methods**. In exchange for the Services detailed in Appendix A, You agree to pay the Practice:

   a. The $50 enrollment fee in full in addition to the monthly fee, which will be prorated for the first month as appropriate, upon signing this Agreement.

   b. The Monthly Membership fee will be due on the same day each month (either the first or 15th as decided on by the patient at time of enrollment). If payment is not received by agreed upon the due date, a late fee of $5 per each day late will be charged for overdue balances.

   c. Eureka Family Health and Wellness may add or discontinue services at any time included in the fee and/or increase the fee schedule one time annually if needed as determined by Eureka Family Health and Wellness and the Patient will be given at least sixty (60) days notice of any such changes.

The Patient and Provider agree that the required method of monthly payment shall be by automatic payment through a credit card, debit card, or direct deposit (ACH transfer).

4. **Renewal and Termination.** This Agreement shall renew on the first of the month. Both the Patient and Eureka Family Health and Wellness shall have the absolute and unconditional right to terminate this agreement at any time without showing any cause for termination, upon giving written notice to the other party. If this Agreement is terminated by either party before the end of an applicable monthly period, the Patient shall pay the monthly membership fee on a prorated basis, number of days of membership provided to the patient, in addition to the full amount of any itemized charges for services rendered to Patient up to the date of termination.

5. **Provider Does Not Participate in Insurance**. Your initials acknowledge Your understanding that the Practice, nor its Provider or employees, will bill any health insurance or HMO plans or panels. We make no representations that any fees paid by you under this Agreement are covered by your health insurance or other third-party payment plans. **Patient Initals: ________**.

6. **This Agreement Is Not Health Insurance.** Your initials acknowledge Your understanding that this Agreement is not an insurance plan nor a substitute for health insurance or other health plan coverage. You acknowledge that this Agreement does not replace any existing or future health insurance or health plan coverage you may carry. This Agreement will not cover hospital services, or any services not personally provided by the Practice, or its employees. Patient acknowledges that the Practice has advised that Patient obtain or keep in full force, health insurance or health share that will cover You for healthcare not personally delivered by the Practice, and for hospitalizations and catastrophic events. **Patient Initals:______**.

7. **Medicare.** If Patient is eligible for Medicare, Patient understands and acknowledges that the Provider has opted out of Medicare. Accordingly, Medicare ***cannot be billed for any services performed for Patient by the Provider.*** Therefore, if you do not disclose your Medicare coverage to the Provider, you may be subject to penalties administered by Medicare. Please see Appendix C. **Patient Initals:________**.

8. **Acceptance of Patients**. We reserve the right to accept or decline patients based upon our capability to appropriately handle the Patient's primary care needs, based on our capacity to provide quality care to our current group of Members, or because the Patient requires medical care not within the Provider's scope of services.

9. **Communications.** You, the Patient, acknowledge that although the Practice shall comply with Health Insurance Portability and Accountability Act (HIPAA) privacy requirements, communications with the Provider using e-mail, facsimile, video, instant messaging, and cell phone, texting, and other forms of electronic communication can never by absolutely secure or confidential methods of communication. Therefore, Patient expressly waives the Provider's obligation to guarantee confidentiality with respect to the above means of communication. Patient further acknowledges that all such communications may become a part of the medical record.

   By providing an e-mail address to Provider in this Agreement and/or during online enrollment, the Patient authorizes the Practice, and its Providers, to communicate with Patient by e-mail regarding the Patient's "protected health information" ("PHI"). The Patient further acknowledges that:

   a. E-mail and texts are not necessarily secure methods for sending or receiving PHI and there is always a possibility that a third party may gain access;

   b. Although the Provider will make all reasonable efforts to keep e-mail and text communications confidential and secure, neither the Practice, nor the Provider can assure or guarantee the absolute confidentiality of e-mail or text communications;

   c. In the discretion of the Provider, e-mail and text communications may be made part of Patient's permanent medical record;

   d. The Provider checks e-mail frequently on weekdays, during regular business hours. If you do not receive a response to an email by the next business day, You agree that you will contact the Practice/Provider by telephone or other means;

   e. Patient understands and agrees that e-mail and text are not an appropriate means of communication in an emergency, for time-sensitive problems, or for disclosing sensitive information. **In an emergency, or a situation in which You could reasonably expect could develop into an emergency, You understand and agree to call 911 or the nearest emergency room, and follow the directions of emergency personnel**. **Patient Initals: ________**.

f. Neither the Practice, nor the Provider, will be liable to me for any loss, cost, injury, or expense caused by or resulting from a delay in responding to me as a result of technical failures including by not limited to, (1) technical failures attributable to any internet service provider, (2) power outages, failure of any electronic messaging software, or failure to properly address e-mail messages,(3) failure of Eureka Family Health and Wellness' computers or computer network, or faulty telephone or cable date transmission, (4) any interception of email or text communications by a third party, or (5) my failure to comply with the guidelines regarding use of e-mail communications set forth in the paragraph.

10. **Provider Absence.** From time to time, due to vacations, illness, or personal emergency, the Provider may be temporarily unavailable to provide the Services as detailed in this Agreement.

11. **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.

12. **Severability.** If any part of this Agreement is deemed to be legally invalid or unenforceable in a court of competent jurisdiction, that part will be amended to the minimum extent necessary to make that provision consistent with applicable law and in its modified form, and the remainder of the contract will stay in force as originally written.

13. **Reimbursement for Services.** If this Agreement is held to be invalid for any reason, and the Practice is required to refund fees paid by Patient, Patient agrees to pay the Practice an amount equal to the fair market value of the Services You received during the time for which the refunded fees were paid.

14. **Amendment.** No amendment of this Agreement shall be binding on this party unless it is in writing and signed by all the parties. Except for amendments made in accordance with Section 12 above.

15. **Assignment.** This Agreement, and any rights You may have under it, may not be assigned or transferred by You.

16. **Dispute Resolution**. In the event Patient has a complaint about the Practice or Provider, Patient will first notify the Practice and/or Provider to resolve the issue.

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

18. **Notice.** All written notices are deemed served if sent by First Class U.S. Mail to the address of the Patient or Provider as written in this Agreement.

With my signature below, I agree to become a Eureka Family Health and Wellness, PLLC, and I agree to the terms outlined in this Member Agreement.

Name Printed:	Provider Name Printed: ___________________________
Patient/ Guardian Signature: ___________________________ Date: ____________________	Provider Signature: ___________________________ Date: ____________________

Membership Effective Date: ________________________, 20________.

APPENDIX A
DIRECT PRIMARY CARE SERVICES

Primary Care Services. Primary Care Services, under this Agreement, are those services that the Provider is permitted to perform under the laws of Montana, are consistent with Provider's training and experience, are usual and customary for a family medicine provider to provide. Some of the conditions and in-office procedures provided by the Practice include the following:

- Acute and Non-acute Office Visits
- Chronic Disease Management
- Well-Woman Care
- Well-Man Care
- Well-Child Care
- Blood Pressure Monitoring
- Diabetic Monitoring
- Breathing Treatments (nebulizer or inhaler with spacer)
- Urinalysis
- Rapid Test for Strep Throat and other in office testing as available
- Removal of benign skin lesions/warts
- Simple aspiration/injection of joint
- Removal of Cerumen (ear wax)
- Abscess Incision and Drainage
- Basic Vision Screening
- consultation and referrals

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

a. Appointments. Unlimited, scheduled, in-person, in-office visits per year are available to Patient. The Practice prefers that Patients schedule visits at least 24 hours in advance. The Practice will accommodate same day appointments as the Provider's schedule allows.

b. Virtual Appointments. Membership allows the Patient unlimited virtual visits, e.g., via e-mail, texting, telephone, and other electronic means, subject to the Provider's policy of responding with a 24 hour period to non-emergency communications.

c. After-Hours Visits. Provider makes no guarantee of after-hours service. This agreement is for ongoing primary care, not emergency or urgent care. Your Provider will make reasonable efforts to see you after hours if Provider is available.

APPENDIX B
FEES and COSTS SCHEDULE

Enrollment Fee. This one-time fee of $ 50_ is charged per plan when the Patient enrolls with the Provider and is non-refundable. If Patient's membership is terminated and Patient seeks to re-enroll as a Member, Patient will be charged a re-enrollment fee of $100 and the Monthly Membership Fee will be continued at the current rate of enrollment, per plan, at the discretion of the Provider.

Monthly Membership Fee. The Monthly fee schedule is as below:
Children are accepted only if enrolled concurrently with an adult.

Child (0-17) {caps at 4 children}	$25
adult age 18 to 49	$50
adult age 50 and up	$75

When an enrolled child turns 18, the monthly fee at the adult rate will be charged on the first month immediately following the birthday. Example, a 17 year old turns 18 on March 15th, the billing rate would change to the adult rate effective April 1st.

Additional Costs. While there are no itemized fees for office visits, and in-office procedures are typically available at no additional cost, the Patient will be charged according to the direct price rate the Practice has negotiated for any necessary laboratory, pathology, specialty supplies, and/or radiology studies

Core Healthcare Members:

Patients who have joined via Core Healthcare and have elected Eureka Family Health and Wellness, PLLC as their Primary Care provider will pay their monthly subscription directly to Core Healthcare and will be provided all services as outlined in that agreement.

APPENDIX C
Eureka Family Health and Wellness, PLLC - MEDICARE PATIENT UNDERSTANDINGS

This agreement is between Eureka Family Health and Wellness DPC, and
Medicare Beneficiary: ____
Who resides at: ____
With Medicare ID #: ________________________

Patient is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Practice has informed Beneficiary or his/her legal representative that Provider has opted out of the Medicare program. The Provider has not been excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Patient, or his/her legal representative agrees, understands and expressly acknowledges the following:

Initial each:
____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.
____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.
____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.
____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.
____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.
____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.
____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him.

Executed on:____________

By: ________________________

Medicare Beneficiary or his/her legal
representative

And: ______________________________

On behalf of Eureka Family Health and
Wellness, PLLC

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also 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 IIHI. 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 IIHI
- your privacy rights in your IIHI
- our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI 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 office 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 QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Eureka Family Health and Wellness, PLLC
Attn: Privacy Officer
239 Front, Bldg A
Eureka, MT 59917
(406)297-3266 phone
(406)297-5312 fax

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI, unless you object:

1. **Treatment.** Our practice may use your IIHI 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 IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice—including, but not limited to, our doctors and nurses—may use or disclose your IIHI in order to treat your or to assist others in your treatment. Additionally, we may disclose your IIHI 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 IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may use and disclose your IHII to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. **Health Care Operations.** Our practice may use and disclose your IIHI 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 IIHI 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. We will share information about you with such insurers or other business associates as necessary to obtain these services.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. 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.

8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

9. **Business Associates.** There are some services provided through contracts with "business associates," such as accounting, legal representation, consulting, medical services, etc. When these services are contracted, we may disclose your IIHI to our business associates so that they can perform the job we have asked them to do and, if applicable, bill you or your third-party payer for services rendered. If we disclose protected health information to a business associate, we will do so subject to a contract that provides that the information will be kept confidential.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI 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

· 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 required or authorized by law to disclose this information

· notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI 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.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI 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.

4. Law Enforcement. We may release IIHI 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, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI 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.

6. **Organ and Tissue Donation.** Our practice may release your IIHI 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.

7. **Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI 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 oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or 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 IIHI of the decedents.

8. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI 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.

9. **Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

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

11. **Inmates.** Our practice may disclose your IIHI 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 safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

E. USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION:

The following uses and disclosures will require your authorization:

1. **Highly Confidential Information:** Federal and State laws require special privacy protections for certain highly confidential information. We will not disclose your medical information 1) maintained in psychotherapy notes; 2) related to mental health treatment, developmental disabilities services, and drug and alcohol abuse treatment; 3) related to HIV status, testing, and treatment as well as any information related to the diagnosis and treatment of sexually transmitted diseases; and 4) genetic information, without, in each case, obtaining your authorization unless otherwise permitted or required by applicable Federal or State law.

2. **Other Uses or Disclosures Requiring Your Specific Authorization:** Other types of uses and disclosures of IIHI not identified in this notice will be made only with your written authorization. Except as permitted under this Notice or as permitted by law, we will request your written authorization before using or sharing your information for marketing purposes or selling your information. Your authorization may be revoked, in writing, at any time. However, should you revoke such an authorization, you should understand that we are unable to retract any disclosures we have already made with your permission, and that we are required to retain our records as proof of the care that we provided you.

F. YOUR RIGHTS REGARDING YOUR IIHI:

The health and billing records we maintain are the physical property of Eureka Family Health and Wellness, PLLC 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 IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI 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 IIHI, 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 IIHI 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 at Eureka Family Health and Wellness PLLC, 239 Front, Bldg, A, Eureka, MT 59917, in order to inspect and/or obtain a copy of your IIHI. Your request should specifically state what medical information you want to inspect or copy. We will ordinarily act on your request within thirty (30) days of our receipt of your request. 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 who did not participate in the original decision to deny access will conduct reviews. We will ordinarily act on your request for review within thirty (30) days.

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 at Eureka Family Health and Wellness, PLLC, 239 Front Street, Bldg A, Eureka, MT 59917. We will ordinarily act on our amendment request within sixty (60) days after our receipt of your request. You must provide us with a reason that supports your request for amendment. If we grant the request, we will inform you of such acceptance in writing. We will make the appropriate amendment to you IIHI, and we will request that you identify and agree that we may notify all relevant persons with whom the amendment should be shared. 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 IIHI kept by or for the practice; (c) not part of the IIHI 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. 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 IIHI for non-treatment or operations purposes. Use of your IIHI 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. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer at Eureka Family Health and Wellness, PLLC, 239 Front, Bldg A, Eureka, MT 59917. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure. 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. We will ordinarily act on your accounting request within sixty (60) days of your request. We are permitted to extend our response time for a period of up to thirty (30) days if we notify you of the extension. We may temporarily suspend your right to receive an accounting of disclosures of your health information, if required to do so by law.

6. Right to Breach Notification: You have a right to receive written notification when a breach (as defined by HIPAA) of your IIHI has occurred. You will receive notification no later than sixty (60) days after the breach has been discovered.

7. Right to a Paper Copy of this Notice. You are entitled to 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.

8. 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. To file a complaint with our practice, contact:

Eureka Family Health and Wellness, PLLC
Attn: Privacy Officer
239 Front, Bldg A, Eureka, MT 59917

All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

9. 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 IIHI may be revoked at any time in writing.

After you revoke your authorization, we will no longer use or disclose your IIHI 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 the Eureka Family Health and Wellness, PLLC's HIPAA Privacy Policy Notice. I understand that I may request additional copies of this notice at any time.

Patient Signature Date

Printed Name