CARAH MEDICAL ARTS

Clinic: 500 Gay St, 1st Floor, Phoenixville, PA 19460
Administrative Office: 317 Church St, Phoenixville, PA 19460
Phone: 484-920-3674
Fax: 484-397-1302

Welcome to Carah Medical Arts! This document contains important agreements and notices that form the written basis of you becoming a Patient Member of Carah Medical Arts. **Please review them carefully. By completing, dating and signing them you confirm that you are the Patient Member or the Patient Member's Authorized Representative, and you enter into and agree to the agreements below that are applicable to you**. In formulating these documents, we have tried to be comprehensive and transparent. Please contact us with any questions.

For EACH Patient Member who is NOT a Medicare Beneficiary and NOT eligible for Medicare benefits:

- Please complete, date and sign the Patient Member Agreement (pages 2-10).
- Please complete, date and sign the Supplemental Patient Member Agreement, if applicable (page 11).
- Please complete, date and sign the Personal Data Sheet (page 12).
- Please complete, date and sign the Payment Authorization (page 13-14).
- Please consider completing, dating and signing the Authorization for Release/Disclosure of Medical Information from your previous primary care physician (page 19).
- You can list your children under age 18 in your forms if you want to sign them up as well.
- Please mail these documents to Carah Medical Arts, 500 Gay Street, 1st Floor, Phoenixville, PA 19460.

For EACH Patient Member who IS a Medicare Beneficiary or eligible for Medicare benefits:

- Please complete, date and sign the Patient Member Agreement (pages 2-10).
- Please complete, date and sign the Supplemental Patient Member Agreement, if applicable (page 11).
- Please complete, date and sign the Personal Data Sheet (page 12).
- Please complete, date and sign the Payment Authorization (page 13-14).
- Please complete, date and sign the Private Contracts with the primary care physicians (Page 15-16 and 17-18).
- Please consider completing, dating and signing the Authorization for Release/Disclosure of Medical Information from your previous primary care physician (page 19).
- Please mail these documents to Carah Medical Arts, 500 Gay Street, 1st Floor, Phoenixville, PA 19460.

Once you have signed up as a Patient Member, you can make appointments online through our website. If you have difficulties with this, please call us at 484-920-3674.

Thank you for joining the Carah Medical Arts community! We are excited to get to know you and to be working with you!

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Administrative Office: 317 Church St, Phoenixville, PA 19460
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Patient Member Agreement

This is an Agreement between Carah Medical Arts, a Pennsylvania non-profit corporation, administrative office located at 317 Church Street, Phoenixville, PA 19460, and You, the Patient Member. If the Patient Member is not legally able to enter into this Agreement, the Patient Member's legally Authorized Representative may enter into this Agreement on the Patient Member's behalf. You confirm that you are the Patient Member or the Patient Member's Authorized Representative and that you will communicate with any other parties as indicated and needed.

Carah Medical Arts operates a medical clinic ("Clinic"). It enters into agreements with Healthcare Practitioners and Therapists to provide healthcare services to its Patient Members and other patients at its clinic. Healthcare Practitioners and Therapists include, but are not necessarily limited to, Primary Care Physicians. In order to exist, Carah Medical Arts needs a community of people and organizations who are willing to support it, for the benefit of their neighbors and community as well as themselves. By becoming a Patient Member, You are joining this community. We strive for transparency in all our communications.

You agree to inform Carah Medical Arts of any changes in your personal information (contact information, payment information etc.) as soon as possible. You agree to immediately inform Carah Medical Arts if the Patient Member becomes a Medicare Beneficiary or eligible for Medicare benefits. If the Patient Member is a Medicare Beneficiary or eligible for Medicare benefits, You may only enter into this Agreement if You also enter into the enclosed Private Contracts with each of the Primary Care Physicians and, if applicable, other Healthcare Practitioners and Therapists at the same time.

If a Patient Member cannot make medical decisions for themselves, Carah Medical Arts, its Healthcare Practitioners and agents will act on the understanding that an adult person (e.g. parent, custodian, power of attorney) who reaches out to Carah Medical Arts for the Patient Member's medical care has the legal standing to do so, make medical decisions for the Patient Member and has and will communicate with any other parties as indicated and needed. Carah Medical Arts does not assume responsibility for ensuring this communication with other parties happens.

If You reside outside of the Commonwealth of Pennsylvania or more than 45 miles away from the Clinic, or if the distance of Your residence from the Clinic makes it difficult for You to come to the Clinic for urgent appointments, You may only enter into this Membership Agreement if You also enter into the Supplemental Patient Member Agreement. You agree to inform Carah Medical Arts if You move your residence outside of the Commonwealth of Pennsylvania or more than 45 miles away from the Clinic, or if the distance of Your residence from the Clinic makes it difficult for You to come to the Clinic for urgent appointments, and to enter into the Supplemental Patient Member Agreement at that point if You continue your Patient Membership at Carah Medical Arts.

1. Services

a. Membership Services

Patient Members have access to primary care services, including preventive care/physical examinations, visits for acute and chronic illnesses, basic psychiatric and gynecological services and procedures (e. g. laceration repair, skin biopsies). Primary care services include integrative medicine. New patient appointments will generally be 55-85 minutes, follow-up appointments and preventive care visits will be 25-55 minutes; appointments for acute illnesses or minor concerns will generally be shorter. Apart from a small supply fee to cover the Clinic's supply costs in the case of a procedure, these services will be available to You without additional cost to Your membership fees (please see section 2 for details). You will also have access to certain remedies at reduced prices. Other healthcare services and therapies, for example osteopathic manual therapy, may be available to you for an additional fee, depending on what is offered at the Clinic. Your Healthcare Practitioner or Therapist will determine when referral to another healthcare practitioner is indicated and necessary.

Carah Medical Arts will make every effort to address Your medical needs in a timely manner, but we cannot guarantee that You will not need to seek treatment in an urgent care, emergency department or hospital setting. Please also see section 1b regarding excluded services which are not part of this Agreement.

Generally, one of the Primary Care Physicians will be primarily responsible for Your care. Based on availability You may see either Primary Care Physician, especially for acute illnesses. The physician on call will be available for phone calls for emergency reasons after hours. If You have non-urgent questions which can wait until the next business day, You have an option to call the Clinic and leave a message or send us an electronic message. Subject to the availability of the Healthcare Practitioner or Therapist, medical need of the Patient Member and distance of the home from the Clinic, home visits may be available. There may be an extra charge for this service. There is no guarantee for home visit availability.

b. Excluded Services

You may need the care of hospitalists, emergency rooms, urgent care centers, hospitals, laboratory testing, radiologic testing, pathology studies, surgery and specialist consultations, medications and other services not directly provided at the Clinic which are outside the scope of this Agreement. Laboratory testing and pathology studies sent from the Clinic to laboratories or pathologists on Your behalf are outside the scope of this Agreement as well. Vaccines and the completion of forms other than physical/preventive care forms are not included in the Membership. You remain financially responsible for the payment of all these Excluded Services. We highly recommend that You maintain health insurance, which may or may not cover the costs of these services. Carah Medical Arts endeavors to provide or refer You to options for Excluded Services that are cost effective for You. For vaccines, this may include obtaining them at the Clinic at the cost incurred by Carah Medical Arts, through pharmacies or Your county health department.

It is the policy of the Healthcare Practitioners to generally not prescribe chronic controlled substances, including commonly abused opioid medications, benzodiazepines and stimulants. If it is necessary to prescribe controlled substances for the treatment of Your condition, You may be required to separately sign our Controlled Substance Treatment Agreement and the shared goal will

generally be to reduce the chronic use of controlled substances over time, except for palliative situations.

2. Fees

As a Patient Member, You agree to pay to Carah Medical Arts the Enrollment Fee, the Monthly Patient Membership Fee, and any additional Itemized Charges incurred for specific services or products (collectively “Fees”).

a. Enrollment Fee

The Enrollment Fee is $60 per household for new Patient Members. “Household” is defined as the immediate family of spouses and/or parents and children (qualifying for the children membership rate as defined in section 2b) residing at the same address. This fee covers the initial administrative cost of Your membership and is not related to the provision of Services.

b. Monthly Patient Membership Fee

Economically, Carah Medical Arts strives to operate out of the ideal of solidarity, of care for one another. We rely on the honest self-evaluation of our members to contribute at the highest membership fee level they can afford. If Your financial situation worsens while You are a Patient Member and You are not able to afford Your current membership level anymore, please be in touch with us as soon as possible. Likewise, if Your financial situation improves and You are able to afford a higher membership level, please let us know as well. Thus, we can jointly cover the financial needs for Carah Medical Arts to exist and maintain continuity of care.

Your Patient Membership Fee is as follows:

- Standard membership fee per person: $85 per month
- Reduced membership fee per person: $68 per month (available for people who cannot afford the standard membership fee)
- Membership fee per child up to 18 years: $40 per month (for children age 19-26 who are students with financial need, this fee can also apply; this fee is available only if another family member contributes at one of the membership levels above)
- Support through the Solidarity and Family Support Fund (see below)

This fee allows access to the services outlined in section 1a in the month for which the fee is received. Please note, that per current IRS regulations, Enrollment and Membership fees are not eligible as Healthcare Savings Account/Healthcare Reimbursement Account expenses. Your monthly fee is due no later than the last day of the month.

Once a child turns 27 and thereby reaches the age limit for the Child Patient Membership Fee level, their membership level will be automatically changed to their parent’s membership level. It is Your responsibility to notify Carah Medical Arts in writing at least one month prior to their birthday if You want to change or terminate their membership at that point or if they are not a student with financial need between age 19 and 26.

A portion of the membership fees will be allocated to a Solidarity and Family Support Fund. Individuals and families who are unable to afford the reduced membership rate may apply for financial support through the Solidarity and Family Support Fund. Please fill out the separate Solidarity and

Family Support Fund Application to apply for this support. Based on a case-by-case needs assessment, financial support of up to 100% is available. It is our goal to enable everyone interested in the care available at our clinic to become and stay a Patient Member, regardless of ability to pay. However, availability of financial support is limited by the funds available in the Solidarity and Family Support Fund at any given time and availability will be based on need, maintaining continuity of care and order of application. Patients Members who pay the Standard or Reduced Fees cannot designate who receives their contribution to the Solidarity and Family Support Fund. A new application for support from the Solidarity and Family Support Fund is required for each twelve-month period. We will notify you when the renewal for your Solidarity and Family Support Fund Application is due. You acknowledge that if you do not renew your application within 30 days after we have sent you this notice, your membership fee will be changed to the reduced membership fee (see above). Carah Medical Arts reserves the right to establish and change processes and eligibility criteria related to the Solidarity and Family Support Fund.

c. Itemized Charges

The fees for Itemized Charges change in response to our costs and Carah Medical Arts endeavors to make these as affordable as possible. These may include osteopathic manual therapy, other therapies or services provided by Healthcare Practitioners or Therapists, remedies, supply fees for procedures, vaccines and others. There is no guarantee of availability of these additional services. You will be made aware of the fees for these services in advance of the services being performed. Payment for these services is due at the time services are rendered. Some services may be offered with a pay-what-you-can model.

If a course of therapy or remedies prescribed by one of our physicians is not affordable for Patient Members, support through a Solidarity and Family Support Fund is available, similar to the support for Patient Membership described under 2.b. Based on a case-by-case needs assessment, financial support of up to 100% is available. It is our goal to enable everyone interested in the care available at our clinic to participate in it, regardless of ability to pay. However, availability of financial support is limited by the funds available for this purpose at any given time and availability will be based on need and order of application. Please complete the corresponding application to apply for this support. Carah Medical Arts reserves the right to establish and change related processes and eligibility criteria.

d. Payment

Fees and charges are payable by automatic debit from Your bank account or credit card. Itemized charges may also be paid by check. By entering into this Agreement, You authorize Carah Medical Arts to charge You the applicable fees and charges under this Agreement via the payment method provided by You. Membership management and payments will be processed through Hint Health, Inc. and Stripe, Inc. Hint Health, Inc. is a company providing membership management and administration services to healthcare providers. Stripe, Inc. provides payment processing services integrated with Hint Health, Inc. By entering into this Agreement, You agree with the use of the services provided by Hint Health, Inc. and its integration with Stripe, Inc. for the management and administration of Your patient membership and Your payments. By entering into this Agreement, You authorize Carah Medical Arts to sign You up on and enter your payment information into the Patient Member Management system provided by Hint Health, Inc. if You have not done so Yourself already.

3. Scheduling

Patient Membership fees provide access to as many primary care office visits at the Clinic as needed. However, Primary Care Physician hours are obviously limited. The fees are based on the expectation that most Patient Members will have up to four Family Medicine office visits per year. Patient Members agree to be mindful that it is every Patient Member's responsibility to the other Patient Members to only schedule appointments that are needed. For the same reason, if You have to cancel an appointment, please do so as soon as possible, but at least 24 hours prior to the appointment.

4. Disclaimer of Non-Insurance and Non-Participation in Health Insurance

Fees paid are not health insurance. You acknowledge that this Agreement is not a health insurance plan, and not a substitute for health insurance or other health plan coverage. This Agreement is a private agreement solely for the services outlined in section 1a. You acknowledge that neither Carah Medical Arts nor the Healthcare Practitioners and Therapists participate in any health insurance or HMO plans. Neither Carah Medical Arts nor the Healthcare Practitioners and Therapists make any representations regarding third party private insurance reimbursement of fees paid under this Agreement, and such reimbursement is not anticipated by this Agreement. The Primary Care Physicians and, if applicable, other Healthcare Practitioners and Therapists have opted out of Medicare. If You are a Medicare Beneficiary or eligible for Medicare benefits, You may only enter into this Agreement when also entering into the enclosed Private Contracts with each of the Primary Care Physicians and, if applicable, other Healthcare Practitioners and Therapists at the same time. You agree not to bill Medicare or attempt Medicare reimbursement for any services or fees paid under this Agreement. Neither Carah Medical Arts nor the Healthcare Practitioners and Therapists participate with Medicaid/Medical Assistance. You acknowledge that neither Carah Medical Arts nor the Healthcare Practitioners and Therapists can bill Medicaid/Medical Assistance for any services or fees paid under this agreement. You agree not to bill Medicaid/Medical Assistance or attempt Medicaid/Medical Assistance reimbursement for any such services or fees.

Some health care sharing plans have policies of reimbursing per visit up to the cost of the monthly membership fee rather than reimbursing for monthly membership fees. This creates an incentive to have appointments with a physician for reimbursement purposes. This practice does not support the community of members supporting Carah Medical Arts and the model that Carah Medical Arts works out of.

We recommend that You ask Your health insurance(s) if it covers prescriptions and orders by physicians and healthcare practitioners who are not in network/not participating and if Your health insurance(s) requires referrals from an in-network primary care physician. Medicaid/Medical Assistance will not cover prescriptions, orders and referrals by the Healthcare Practitioners and Therapists. Neither Carah Medical Arts nor the Healthcare Practitioners and Therapists make any representations regarding third party insurance coverage of prescriptions, orders and referrals written by the Healthcare Practitioners and Therapists. The coverage of these is not part of this Agreement and payment for these remains Your responsibility; please also refer to section 1b.

5. Term and Termination

This Agreement will become effective on the date of Your signature and shall have an initial term of four (4) months. Upon the expiration of the initial term, this Agreement shall automatically renew for

successive monthly terms upon the payment of the Monthly Fee, until the Agreement is terminated. Both You and Carah Medical Arts shall have the right to terminate the Agreement, without cause. Any provisions of this Agreement creating obligations extending beyond the term of this Agreement shall survive the expiration or termination of this Agreement, regardless of the reason for such termination.

You are under no obligation to continue receiving services and You may terminate this Agreement, in writing, at any time. If You decide to terminate this Agreement during the first four months after its effective date, You will be responsible for the full Patient Membership Fee charges for four (4) months, plus any additional Itemized Charges incurred. After this initial four-month period, You will be responsible for the entire month's fee in which the termination occurred, plus any additional Itemized Charges incurred. Once You terminate this Agreement, You will not be eligible for any services under this Agreement, including medication refills. If You wish to re-enroll at a later date, You will have to enter into a new agreement with Carah Medical Arts and Carah Medical Arts reserves the right to decline such re-enrollment. Notwithstanding any other provision of this Agreement, if Your decision to terminate is based on a grievance with Carah Medical Arts or the Healthcare Practitioners or Therapists, You will give us an opportunity to make it right, prior to issuing Your written notice of termination or taking other action.

If Carah Medical Arts elects to terminate this Agreement, it will provide You with thirty (30) days written notice. There are certain circumstances in which Carah Medical Arts may choose to terminate this Agreement. Such circumstances may include, but are not limited to, You failing to pay fees and charges when they are due or the Clinic discontinuing operation.

6. Consent to Treat, Privacy & Communications

By signing this Agreement, You authorize Carah Medical Arts and the Healthcare Practitioners and Therapists to use and/or disclose Your Protected Health Information ("PHI") to carry out Your treatment, the coordination of Your healthcare, other healthcare operations and to obtain payments and fees under this Agreement. Carah Medical Arts and the Healthcare Practitioners and Therapists will adhere to their obligations regarding Your privacy rights as identified in the enclosed Patient Notice of Privacy Practices.

By entering into this Agreement, You acknowledge that You have received or were offered a copy of the Patient Notice of Privacy Practices. Carah Medical Arts reserves the right to change its Patient Notice of Privacy Practices as it sees fit from time to time.

You acknowledge that communications from Carah Medical Arts and the Healthcare Practitioners and Therapists may include electronic mail, facsimile, video chat, instant messaging, and phone, and such communications by their nature cannot be guaranteed to be secure or confidential. Unless You object in writing, You authorize, by entering into this Agreement, Carah Medical Arts and the Healthcare Practitioners and Therapists to communicate with You using these communication platforms and You acknowledge that these communications may include unencrypted PHI. This will allow Carah Medical Arts to exchange information with You more efficiently and will benefit You as a Patient Member. You may object to the use of these methods of communication and a decision to not authorize these methods of communication will not affect the health care offered to You. Carah Medical Arts and the Healthcare Practitioners and Therapists have taken considerable effort to protect Your personal health information and recommend that all Patient Members provide us with

this authorization so that we can more efficiently communicate with them. If You initiate communication in which You disclose PHI on any of the communication platforms mentioned in this section 6 (electronic mail, facsimile, video chat, instant messaging, and phone), You authorize Carah Medical Arts and the Healthcare Practitioners and Therapists to communicate with You regarding all PHI in the same format.

Carah Medical Arts is a membership organization. Unless You object in writing, You agree to be included in our mailing list and receive membership communications (e. g. regarding news, events and membership activities) from Carah Medical Arts. You also have the possibility to opt out of our mailing list and membership communications at a later time.

7. Miscellaneous

a. Changes

Carah Medical Arts reserves the right to make changes to this Agreement including Fees at any time with forty-five (45) days' written notice to You. If Carah Medical Arts does not receive a written response from You within this time period, Your consent to the changes is implied. Fees for Itemized Charges may be changed without such advance written notice, but You will be informed of these prior to the service being provided.

b. Entire Agreement

This Agreement constitutes the entire agreement between Carah Medical Arts and You with respect to the subject matter hereof, and supersedes any and all other agreements, understandings, or representations, oral or written, between Carah Medical Arts and You with respect to the subject matter hereof.

c. Non-Discrimination

Under no circumstances will Carah Medical Arts or the Healthcare Practitioners or Therapists discriminate against You, or terminate this Agreement, on the basis of race, color, religion, marital status, national origin, sex, gender expression, age, disability or sexual orientation. However, Carah Medical Arts and the Healthcare Practitioners and Therapists reserve the right to accept or decline Patient Members based upon their capability to appropriately manage the needs of our Patient Members.

d. No Waiver

No waiver of a breach of any provision of this Agreement will be construed to be a waiver of this Agreement, whether of a similar or different nature, and no delay in acting with regard to a breach shall be construed as a waiver of that breach.

e. Governing Law

This Agreement shall be subject to and governed by the laws of the Commonwealth of Pennsylvania, without regard to Pennsylvania's choice of law provision and without regard to any conflicts of law provisions therein contained. All disputes arising out of this Agreement shall be settled by binding arbitration. The provider of arbitration services shall be chosen solely at Carah Medical Art's discretion and costs of arbitration shall be borne equally by the parties.

f. Notices

Any notices or payments required or permitted to be given under this Agreement shall be deemed given when in writing, by electronic transmission, hand delivered, or with deposit in the United States mail. Any change in address of either Party will be communicated prior to the address change by the Party changing address.

g. Severability

If any provision of this Agreement shall be deemed, by a court of competent jurisdiction, to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of the Agreement shall not be affected, and the offending provision shall be deemed modified to the minimum extent necessary to make that provision consistent with applicable law, and that provision shall then be enforceable.

8. PATIENT MEMBER ACKNOWLEDGEMENTS

Please read each line carefully. By entering into this Agreement, You acknowledge the following in addition to what is set forth in the other sections of this Agreement.

- You acknowledge that Carah Medical Arts has advised You to maintain health insurance for coverage of all Services not specifically provided for in this Agreement. You further acknowledge that this Agreement is not a contract that provides health insurance.
- You acknowledge that You do not expect Carah Medical Arts or the Healthcare Practitioners or Therapists to file or issue any third party insurance claims on Your behalf.
- You acknowledge that, if the Patient Member is a Medicare beneficiary or eligible for Medicare Benefits, You have reviewed and are entering into the enclosed Private Contracts with the Primary Care Physicians and, if applicable, other Healthcare Practitioners and Therapists also. You acknowledge that You will not bill Medicare or attempt Medicare reimbursement for services provided to You or fees paid under this Agreement.
- You agree to immediately inform Carah Medical Arts if the Patient Member becomes a Medicare Beneficiary or eligible for Medicare benefits.
- You acknowledge that You will not bill Medicaid/Medical Assistance or attempt Medicaid/Medical Assistance reimbursement for services provided to You or fees paid under this Agreement.
- You acknowledge that You have received or were offered a copy of the Patient Notice of Privacy Practices.
- Unless you object in writing, You authorize Carah Medical Arts and the Healthcare Practitioners and Therapists to communicate with You using electronic mail, facsimile, video chat, instant messaging, and phone. You acknowledge that such communications by their nature cannot be guaranteed to be secure or confidential and that they may include unencrypted Protected Health Information. Unless You object in writing, You agree to be included in our mailing list and receive membership communications from Carah Medical Arts. Please see section 6 for details.
- By signing this Agreement, You authorize Carah Medical Arts to charge you the applicable fees under this Agreement via the payment method provided by You on the Payment Authorization form and to sign You up on and enter your payment information into the Patient Member Management system provided by Hint Health, Inc. if You have not done so Yourself already.
- In the event of a true medical emergency, You agree to call 911 first.

This Agreement constitutes the valid and enforceable obligations of the parties in accordance with its terms. This Agreement becomes effective on the date of Your signature.

Patient Member name:_____

Patient Member date of birth (MM/DD/YYYY):_____

Your preferred primary physician at Carah Medical Arts may have a waiting list at this time. Please check online at carahmedicalarts.org under “Join Us”, “New Patient Members” or inquire via phone if your preferred physician is accepting new Patient Members.

Choice for primary physician at Carah Medical Arts (please check one): O Dr. Knauf O Dr. Greer

If you want to sign up children under the age of 18 in your household as Patient Members as well and enter into this Agreement on their behalf also, please list them here:

Child Patient Member 1 name:_____

Child Patient Member 1 date of birth (MM/DD/YYYY):_____ Gender:_____

Choice for primary physician at Carah Medical Arts (please check one): O Dr. Knauf O Dr. Greer

Child Patient Member 2 name:_____

Child Patient Member 2 date of birth (MM/DD/YYYY):_____ Gender:_____

Choice for primary physician at Carah Medical Arts (please check one): O Dr. Knauf O Dr. Greer

Child Patient Member 3 name:_____

Child Patient Member 3 date of birth (MM/DD/YYYY):_____ Gender:_____

Choice for primary physician at Carah Medical Arts (please check one): O Dr. Knauf O Dr. Greer

Child Patient Member 4 name:_____

Child Patient Member 4 date of birth (MM/DD/YYYY):_____ Gender:_____

Choice for primary physician at Carah Medical Arts (please check one): O Dr. Knauf O Dr. Greer

Please check if applicable:
O My family member listed here also is a patient member at Carah Medical Arts. Please add my membership to this person’s membership. I am aware that this person will receive invoices related to my membership and related services from Carah Medical Arts.

Family member:_____ Date of birth (MM/DD/YYYY):_____

Date (MM/DD/YYYY):_____

_____ _____

Printed name of Authorized Representative (if different from Patient Member) Relationship to Patient Member

_____

Signature of Patient Member/Authorized Representative

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Supplemental Patient Member Agreement

(Please complete a separate Supplemental Patient Member Agreement for each Patient Member)

This Supplemental Patient Member Agreement (Agreement) is an agreement between Carah Medical Arts, a Pennsylvania non-profit corporation, registered address 317 Church Street, Phoenixville, PA 19460 and You, the Patient Member. If You reside outside of the Commonwealth of Pennsylvania or more than 45 miles away from the clinic operated by Carah Medical Arts ("Clinic"), or if the distance of Your residence from the Clinic makes it difficult for You to come to the Clinic for urgent appointments, You may enter into the Patient Member Agreement only if You also enter into this Supplemental Patient Member Agreement. If the Patient Member is not legally able to enter into this Agreement, the Patient Member's legally Authorized Representative may enter into this Agreement on the Patient Member's behalf.

Carah Medical Arts strives to make Patient Membership accessible to anyone who wants to join the community supporting it and access the medical care offered at Carah Medical Arts. Our approach to healthcare strives for integrative primary care, long-lasting, collaborative relationships, and economics based on caring for each other. However, primary care services typically include availability for urgent health issues and other health issues that limit mobility. If Your living situation meets one or more of the criteria listed in the first paragraph of this Agreement, it is Your responsibility that You have an active, current patient-doctor relationship with and receive Your primary care from another primary care physician accessible to You (not at Carah Medical Arts) while You are a Patient Member of Carah Medical Arts.

By signing below, You confirm and acknowledge that You have and will maintain an active, current patient-doctor relationship with and receive your primary care from the primary care physician listed below and that this primary care physician is accessible to You. This includes but is not limited to receiving care for urgent health issues and counseling on recommended screening examinations from this physician. You further confirm and acknowledge that, if You decide to end your patient-doctor-relationship with the physician listed below, You will immediately establish care with another primary care physician accessible to You (not at Carah Medical Arts) and maintain an active, current patient-doctor relationship with and receive Your primary care from that primary care physician. You agree to immediately inform Carah Medical Arts of any such change.

Primary Care Physician: Name:_____

Street address:_____ Town, state & zip code:_____

Phone number:_____ Fax number:_____

Patient Member name:_____

Date of birth (MM/DD/YYYY):_____

Date (MM/DD/YYYY):_____

_____ _____

Printed name of Authorized Representative (if different from Patient Member) Relationship to Patient Member

_____

Signature of Patient Member/Authorized Representative

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Personal Data Sheet

Name of Patient Member:_____

Date of Birth (MM/DD/YYYY):_____

Gender: _____

Street Address:_____

Town, State and Zip Code:_____

Phone number 1 (preferred):_____ Phone number 2:_____

Email:_____

Health Insurance (optional; this information helps to send off laboratory and diagnostic imaging orders)

Name:_____

Primary Insured:_____

Member ID:_____ Group ID:_____

Child Patient Member 1 Member ID: _____

Child Patient Member 2 Member ID: _____

Child Patient Member 3 Member ID: _____

Child Patient Member 4 Member ID: _____

If the children listed on the Patient Member Agreement have a different health insurance plan, please consider attaching an extra sheet with their complete insurance information.

My children who I have listed on the Patient Member Agreement have the same contact information, unless I indicate otherwise.

Date (MM/DD/YYYY):_____

_____ _____

Printed name of Authorized Representative (if different from Patient Member) Relationship to Patient Member

_____

Signature of Patient Member/Authorized Representative

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Payment Authorization (Page 1)

Name of Patient Member:_____

Date of Birth (MM/DD/YYYY):_____

If another adult from your household is signing up as a Patient Member, you may include them on this Payment Authorization form. Please list their name and date of birth here:

Name of additional adult Patient Member:_____

Date of Birth (MM/DD/YYYY):_____

O Please check here if the Patient Member above should be added to the already existing membership of the person signing at the very bottom of page 2. You do not need to complete the Payment Method and Membership Fees sections.

Payment Method (please check and complete one option)

○ Automatic electronic debit from your bank account (preferred because of lowest cost to Carah Medical Arts; the account holder needs to sign the form):

Routing Number:_____

Account Number:_____

Please attach a voided check to this form. You may also write "see check" in the lines above.

○ Automatic electronic payment via debit or credit card (the card holder needs to sign the form):

O Visa O Mastercard

Card number:_____

Card expiration date (MM/YY):_____ CVC security code:_____

Membership Fees

Enrollment Fee (one-time fee, please check and complete one option):

O Standard enrollment fee

O Another household member is already signed up as a Patient Member;

Name:_____ Date of Birth (MM/DD/YYYY): _____

O I/We have been approved for support through the Solidarity Fund.

Patient Membership Fee (due every month, please check and complete options applicable to you; if other household members are already signed up as Patient Members, please check the kind of membership – standard, reduced, or Solidarity Fund – and the number of NEW patient members):

O Standard Patient Membership Fee for O one (1) O two (2) people

O I am/we are not able to afford the standard Patient Membership Fee. Reduced Patient Membership Fee for O one (1) O two (2) people

O I am also signing up O one (1) O two (2) O three (3) O four (4) O _____ children.

O I/We have been approved for support through the Solidarity Fund.

I hereby authorize Carah Medical Arts to charge me the applicable fees per the Patient Member Agreement for the options selected on page 1 of the Payment Authorization via the payment method provided on page 1 of the Payment Authorization. If other household members are already signed up as Patient Members, the previously provided payment authorization for them remains in effect.

Once a child turns 27 and thereby reaches the age limit for the Child Patient Membership Fee level, their membership level will be automatically changed to their parent's membership level. I understand that it is my responsibility to notify Carah Medical Arts in writing at least one month prior to their birthday if we want to change or terminate their membership at that point.

If Patient Membership Fees change, I will be informed by Carah Medical Arts in writing. Unless I object in writing, this Payment Authorization will remain valid for the new Patient Membership Fees.

I acknowledge that communications from Carah Medical Arts and the Healthcare Practitioners and Therapists may include electronic mail, facsimile, video chat, instant messaging, and phone, and such communications by their nature cannot be guaranteed to be secure or confidential. Unless I object in writing, I authorize, Carah Medical Arts and the Healthcare Practitioners and Therapists to communicate with me using these communication platforms and I acknowledge that these communications may include unencrypted Protected Health Information. I authorize Carah Medical Arts to use the personal information entered below or on the Personal Data Sheet to process my payments. I authorize Carah Medical Arts to sign us up on and enter our payment information into the Patient Member Management system provided by Hint Health, Inc. (Please see the Patient Member Agreement for details.)

Date (MM/DD/YYYY):_____

_____ _____

Printed name of Authorized Representative (if different from Patient Member) Relationship to Patient Member

_____

Signature of Patient Member/Authorized Representative

Please complete below if bank account/credit card holder is different from Patient Member:

Name of account holder:_____

Date of Birth (MM/DD/YYYY):_____

O Please check if contact information already on file

Street Address:_____

Town, State and Zip Code:_____

Phone number:_____ Email:_____

Date (MM/DD/YYYY):_____

_____ _____

Printed name of bank account/credit card holder (if different from Patient Member) Relationship to Patient Member

_____

Signature of bank account/credit card holder (if different from Patient Member)

MEDICARE PRIVATE CONTRACT – RAPHAEL KNAUF, MD

(IN COMPLIANCE WITH 42 U.S.C. §1395a; 42 C.F.R. § 405, SUBPART D)

This contract is entered into by and between Raphael J. Knauf, MD ("Physician"), and the Patient Member ("Beneficiary"). The Physician has informed the Beneficiary that Physician has opted out of the Medicare program effective as of October 1, 2023, for a period of at least two years. This contract shall become effective on the day it is entered into by the Beneficiary and shall expire on the 1st day of October 2025 ("Opt-out period"), unless otherwise renewed in accordance with the 42 U. S. C. 1395a; 42 C.F.R. 405, Subpart D.

Physician Obligations

The Physician acknowledges that he is not excluded from Medicare under sections 1128, 1156, 1892 or any other section of the Social Security Act.

The Physician acknowledges that this contract shall not be entered into with the Beneficiary, or the Beneficiary's legal representative, during a time when the Beneficiary requires emergency care services or urgent care services, except that the Physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The Physician acknowledges that he must retain this contract (with original signatures of both parties to this contract) for the duration of the Opt-out period, and that it shall be made available to the Centers for Medicare and Medicaid Services (CMS) upon request.

The Physician shall provide a copy of this contract to the Beneficiary, or to his or her legal representative, before items or services have been furnished to the Beneficiary under the terms of this contract.

The physician acknowledges that he must enter into a contract for each opt-out period.

Beneficiary Obligations

The Beneficiary, or his or her legal representative, accepts full responsibility for payment of the charges for all services furnished by the Physician.

The Beneficiary, or his or her legal representative, understands that no payment will be provided by Medicare for 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.

The Beneficiary, or his or her legal representative, understands that Medicare limits or any other Medicare reimbursement regulations do not apply to what may be charged for items or services furnished by the Physician.

The Beneficiary, or his or her legal representative, agrees not to submit a claim, nor ask the Physician to submit a claim, to Medicare for Medicare items or services, even if such items or services are otherwise covered by Medicare.

The Beneficiary, or his or her legal representative, acknowledges that this written private contract contains sufficiently large print to ensure that the Beneficiary, or his or her legal representative, is able to read this contract.

The Beneficiary, or his or her legal representative, has entered into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare and for whom payment would be made by Medicare for their covered services, and that the Beneficiary has not been compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

The Beneficiary, or his or her legal representative, understands that Medigap plans do not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

The Beneficiary, or his or her legal representative, understands that this agreement shall not be entered into with the Physician during a time when the Beneficiary requires emergency care services or urgent care services, except that the Physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The Beneficiary, or his or her legal representative, acknowledges that a copy of this contract has been provided to the Beneficiary, or to his or her legal representative, before items or services have been furnished to the Beneficiary under the terms of this contract.

The Beneficiary, or his or her legal representative, understands that during the Opt-out period, a Medicare Advantage plan may not by law make any payments to the Physician for any Medicare items and services furnished to the Beneficiary under this contract.

Raphael J. Knauf, MD	1912294992
Name of Physician	National Provider Identifier

Contact: c/o Carah Medical Arts, 500 Gay St, 1st Fl, Phoenixville, PA 19460; phone: 484-920-3674.

_____	_____
Signature of Physician	Date (MM/DD/YYYY)
_____	_____
Name of Beneficiary	Date of Birth (MM/DD/YYYY)
_____	_____
Name of Legal Representative (if different from above)	Relationship to Patient Member
_____	_____
Signature of Beneficiary or Legal Representative	Date (MM/DD/YYYY)

MEDICARE PRIVATE CONTRACT – MELISSA GREER, DO

(IN COMPLIANCE WITH 42 U.S.C. §1395a; 42 C.F.R. § 405, SUBPART D)

This contract is entered into by and between Melissa A. Greer, DO ("Physician"), and the Patient Member ("Beneficiary"). The Physician has informed the Beneficiary that Physician has opted out of the Medicare program effective as of October 1, 2023, for a period of at least two years. This contract shall become effective on the day it is entered into by the Beneficiary and shall expire on the 1st day of October 2025 ("Opt-out period"), unless otherwise renewed in accordance with the 42 U. S. C. 1395a; 42 C.F.R. 405, Subpart D.

Physician Obligations

The Physician acknowledges that she is not excluded from Medicare under sections 1128, 1156, 1892 or any other section of the Social Security Act.

The Physician acknowledges that this contract shall not be entered into with the Beneficiary, or the Beneficiary's legal representative, during a time when the Beneficiary requires emergency care services or urgent care services, except that the Physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The Physician acknowledges that she must retain this contract (with original signatures of both parties to this contract) for the duration of the Opt-out period, and that it shall be made available to the Centers for Medicare and Medicaid Services (CMS) upon request.

The Physician shall provide a copy of this contract to the Beneficiary, or to his or her legal representative, before items or services have been furnished to the Beneficiary under the terms of this contract.

The physician acknowledges that she must enter into a contract for each opt-out period.

Beneficiary Obligations

The Beneficiary, or his or her legal representative, accepts full responsibility for payment of the charges for all services furnished by the Physician.

The Beneficiary, or his or her legal representative, understands that no payment will be provided by Medicare for 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.

The Beneficiary, or his or her legal representative, understands that Medicare limits or any other Medicare reimbursement regulations do not apply to what may be charged for items or services furnished by the Physician.

The Beneficiary, or his or her legal representative, agrees not to submit a claim, nor ask the Physician to submit a claim, to Medicare for Medicare items or services, even if such items or services are otherwise covered by Medicare.

The Beneficiary, or his or her legal representative, acknowledges that this written private contract contains sufficiently large print to ensure that the Beneficiary, or his or her legal representative, is able to read this contract.

The Beneficiary, or his or her legal representative, has entered into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare and for whom payment would be made by Medicare for their covered services, and that the Beneficiary has not been compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

The Beneficiary, or his or her legal representative, understands that Medigap plans do not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

The Beneficiary, or his or her legal representative, understands that this agreement shall not be entered into with the Physician during a time when the Beneficiary requires emergency care services or urgent care services, except that the Physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The Beneficiary, or his or her legal representative, acknowledges that a copy of this contract has been provided to the Beneficiary, or to his or her legal representative, before items or services have been furnished to the Beneficiary under the terms of this contract.

The Beneficiary, or his or her legal representative, understands that during the Opt-out period, a Medicare Advantage plan may not by law make any payments to the Physician for any Medicare items and services furnished to the Beneficiary under this contract.

Melissa A. Greer, DO	1467779819
Name of Physician	National Provider Identifier

Contact: c/o Carah Medical Arts, 500 Gay St, 1st Fl, Phoenixville, PA 19460; phone: 484-920-3674.

_____	_____
Signature of Physician	Date (MM/DD/YYYY)
_____	_____
Name of Beneficiary	Date of Birth (MM/DD/YYYY)
_____	_____
Name of Legal Representative (if different from above)	Relationship to Patient Member
_____	_____
Signature of Beneficiary or Legal Representative	Date (MM/DD/YYYY)

CARAH MEDICAL ARTS

500 Gay Street, 1st Floor
Phoenixville, PA 19460
Phone: 484-920-3674
Fax: 484-397-1302

Authorization for Release/Disclosure of Medical Information

This authorization gives permission to release and disclose health information about the named individual to Carah Medical Arts.

Patient Name:_____ Date of Birth (MM/DD/YYYY): _____

Please enter name and, if available, address of healthcare entity whom you authorize to disclose health information on the line below:

_____

is authorized to release and disclose the health information of the above named individual as described in this authorization:

Recipient: The covered health information may be released and disclosed to:
Carah Medical Arts, 500 Gay Street, 1st Floor, Phoenixville, PA 19460, Phone: 484-920-3674, Fax: 484-397-1302.

Description of Information to be Released: Identify specifically the information that should be released to the above recipient (e. g. progress notes, results of diagnostic testing, consult notes):

_____

_____

Psychotherapy notes will not be covered unless specifically covered in a separate authorization. Please note that other mental health and behavioral information included in any checked category will be covered by this authorization unless excluded below.

Specially protected information: The following information is specially protected by state and/or federal law. Please indicate below whether you would like the following information to be released.

Substance abuse records (drug or alcohol)	Yes ❑	No ❑	Initials ____
Mental health records protected by the Mental Health Procedures Act	Yes ❑	No ❑	Initials ____
HIV/AIDS related information	Yes ❑	No ❑	Initials ____

Purpose for the Disclosure: I am requesting use or disclosure of the covered health information for the purpose of continued medical care.

I understand that I have the following rights:

- **Right not to sign.** Refusal to sign will not affect my ability to obtain treatment at the clinic operated by Carah Medical Arts.
- **Right to revoke.** I may revoke this authorization in writing at any time. My revocation will not apply to any actions that have already been taken in reliance on this authorization.

Re-disclosure. I understand that once the covered health information has been disclosed, it may be no longer protected by privacy laws and may be re-disclosed by the recipient.

Expiration: This authorization expires as of the following date or event_____

I have read and understand this authorization, and authorize the release and disclosure of the covered health information as described in this authorization.

_____ _____

Name of Authorized Representative (if different from patient) Relationship to Patient

_____ _____

Signature of Patient/Authorized Representative Date (MM/DD/YYYY)

Clinic: 500 Gay St, 1st Floor, Phoenixville, PA 19460
Administrative Office: 317 Church St, Phoenixville, PA 19460
Phone: 484-920-3674
Fax: 484-397-1302

Patient Notice of Privacy Practices

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

Effective Date of this Notice: January 18, 2021

If you have any questions regarding this Notice, you may contact us at:

Address: Carah Medical Arts
Attn: Privacy Officer
500 Gay Street, 1st Floor
Phoenixville, PA 19460
Phone: 484-920-3674
Fax: 484-397-1302

I. YOUR PROTECTED HEALTH INFORMATION AND OUR RESPONSIBILITIES

The privacy and safety of your Protected Health Information ("PHI") is very important to us. This Notice describes how medical information about you/your PHI may be used and disclosed and how you can get access to this information. Carah Medical Arts, the health care practitioners and therapists providing services at its Clinic and its staff ("we") will abide by the terms of the Notice currently in effect. We will notify you following a breach of your PHI. We will not use or share your PHI other than described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Generally speaking, your PHI is any information that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or payment for health care provided to you, and individually identifies you or reasonably can be used to identify you. PHI includes genetic information. Your medical and billing/payment records are examples of information that usually will be regarded as your PHI.

If you have authorized us to do so, communications from us may include electronic mail, facsimile, video chat, instant messaging, and phone, and such communications by their nature cannot be guaranteed to be secure or confidential. You may object to the use of these methods of communication and a decision to not authorize these methods of communication will not affect the health care offered to you. If you initiate communication in which you disclose PHI on any of these communication platforms (electronic mail, facsimile, video chat, instant messaging, and phone), you authorize us to communicate with you regarding all PHI in the same format.

II. USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

A. Treatment, payment, and health care operations

This section describes how we may use and disclose your PHI for treatment, payment, and health care operations purposes. The descriptions include examples. Not every possible use or disclosure for treatment, payment, and health care operations purposes will be listed.

1. Treatment

We may use and disclose your PHI for our treatment purposes as well as the treatment purposes of other health care providers. Treatment includes the provision, coordination, or management of health care services to you by one or more health care providers. Some examples of treatment uses and disclosures include:

- We may disclose medical information about you to doctors, nurses, technicians, medical students and other trainees, or other personnel who are involved in your care at our office.
- We may share medical information about you in order to coordinate the different services you need, such as prescriptions, lab work and x-rays.
- We may disclose medical information about you to people outside our clinic who may be involved in your medical care, such as other health care practitioners, family members, care givers or other health care related entities such as skilled nursing care facilities with whom you seek treatment.
- We may use a patient sign-in sheet in the waiting area which is accessible to all patients.
- We may call patients in the waiting room when it is time for them to go to an examining room.
- We may contact you to provide appointment reminders or notices about changes to the Patient Member Agreement or Private Contracts.

2. Payment

We may use and disclose your PHI for our payment purposes so that Enrollment Fees, Membership Fees, treatment and services you receive may be billed and payment may be collected from you or your authorized representative. We may use and disclose your protected health information for the payment purposes of other health care providers so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. We will disclose your PHI for the payment purposes of other health care providers only if necessary for treatment and services ordered or requested by the healthcare practitioners or therapists working at the clinic operated by Carah Medical Arts (for example for laboratory testing, pathology studies, diagnostic imaging, ambulance services and the like). Some examples of payment uses and disclosures include:

- Mailing or electronically sending bills or statements to you for Enrollment Fees, Membership Fees, treatment and services you received.
- Provision of a bill to a family member or other person designated as responsible for payment for services rendered to you.

3. Health care operations

We may use and disclose your PHI for our health care operation purposes. Some examples of health care operation purposes include:

- We may use and share your PHI for running our clinic and contacting you when necessary.
- We may use medical information to review and improve our treatment and services.
- We may use medical information about you for various quality assurance and quality improvement activities within our clinic.
- Accreditation, certification, licensing, and credentialing activities.

- Other business management and general administrative activities, such as compliance with the resolution of patient grievances and customer service.
- We may remove information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of patients.
- Conducting fundraising activities. With any fundraising communication, you will be given the opportunity to opt out of future solicitations.

B. Other uses and disclosures not requiring authorization

We may use and disclose your PHI for other purposes.

- Unless you object, we may disclose health information about you to family members, caregivers and friends who are involved in your care. We may also give information to someone who is involved in your payments to Carah Medical Arts.
- In a disaster relief effort so that your family can be notified about your condition and location.
- A government disaster relief agency if you are involved in a disaster relief effort.
- To inform you of treatment alternatives, benefits, or services related to your health.
- To contact you to raise funds for Carah Medical Arts. Information used and disclosed for fundraising will be limited to your name and other limited information permitted by law. You will have the opportunity to opt out of receiving future fundraising communications.
- As required by law.
- Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect or domestic violence (if you agree or as required by law).
- Health oversight activities (e.g., audits, inspections, investigations, and licensure activities).
- Lawsuits and disputes (e.g., as required by a court or administrative order or in response to a subpoena or other legal process).
- Law enforcement (e.g., in response to legal process or as required or allowed by law).
- Coroners, medical examiners, and funeral directors.
- Organ and tissue donation organizations.
- Certain research projects as approved by a special approval process or if certain conditions are met.
- To prevent or lessen a serious threat to health or safety.
- To military authorities if required by them and if you are or were a member of the armed forces.
- National security and intelligence activities and presidential protective services.
- Should you become an inmate of a correctional institution or be otherwise in custody, we may disclose your PHI to a correctional institution or law enforcement.
- Workers' Compensation (in compliance with applicable laws).
- To business associates (individuals or entities that perform functions on our behalf) (e.g., membership management provider, payment processing provider, electronic health record provider, administrative support provider) so that they can perform the job we have asked them to do and provided they agree to safeguard the information.
- We may incidentally disclose PHI as by-product of an otherwise permitted use or disclosure. For example, other patients may overhear your name being called in the waiting room.
- We may disclose proof of immunization to a school for admission with oral or written agreement from a parent/guardian or other person acting in *loco parentis*, or directly from the individual if an adult or emancipated minor.

- Carah Medical Arts may include your contact information on its mailing list and send you membership communications (e. g. regarding news, events and membership activities). You have the possibility to opt out of our mailing list and membership communications at any time.

C. Uses and disclosures requiring authorization

All other purposes that do not fall under a category listed above, will require your written authorization to use or disclose your PHI. We will never sell your PHI. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes or use or disclose your health information for marketing purposes, unless you have signed an authorization. You may revoke your authorization, and thereby stop any future uses and disclosures, by notifying us in writing.

III. PATIENT PRIVACY RIGHTS

You have the following rights regarding your medical records. Please contact our Privacy Officer to exercise your rights.

A. Right to request restriction

You may request limitations on how we use or disclose your medical information for health care treatment, payment, or operations (e.g., you may ask us not to disclose that you have had a particular surgery). We are not required to agree to your request, except for requests to restrict disclosures to a health plan for purposes of payment or health care operations when you have paid in full out-of-pocket for the item or service covered by the request and when the disclosure is not required by law. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

B. Right to confidential communications

You may request communications in a certain way or at a certain location. For example, you might request that we only contact you by mail or at work. We will accommodate reasonable requests for confidential communications but you must specify how or where you wish to be contacted and how payment will be handled.

C. Right to accounting of disclosures

You may request a list of instances where we have disclosed your medical information for certain types of disclosures. The accounting will not include disclosures that we are not required to record, such as disclosures made pursuant to an authorization and those about treatment, payment and healthcare operations. This right is limited to disclosures within six years of the request. The first accounting you request within a 12-month period is free, but we will charge a fee for any additional lists requested within the same 12-month period.

D. Right to inspect and copy

You have the right to look at and obtain a copy of your medical records, billing records, and other records used to make decisions about your care. We may charge you a fee for our postage and labor costs and supplies to create the copy. Under limited circumstances, your request may be denied and you may request review of the denial by another licensed health care professional of our choosing. We will comply with the outcome of the review. If your information is stored electronically and you request an electronic copy, we will provide it to you in a readable electronic form and format.

E. Right to request amendment

If you believe that the medical information we have about you is incorrect or incomplete, you have the right to request that your records be amended. Under limited circumstances, we may deny your request for amendment. If denied, you will receive an explanation for the decision and information explaining your options.

F. Right to copy of privacy notice

You may request a paper or electronic copy of this Notice at any time by contacting our Privacy Officer. You may also obtain an electronic copy of this Notice on our website. We will provide you with a copy promptly.

G. Right to notification of breach

We are required by law to notify affected individuals following a breach of unsecured medical information. A breach is generally defined as any disclosure of unsecured protected health information not permitted by this notice. Examples of exceptions include unintentional access by employees and inadvertent disclosures within an office.

F. 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 exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

IV. CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We further reserve the right to make any new provisions effective for all protected health information that we maintain at the time of the change, including information that we created or received prior to the effective date of the change. We will post a copy of our current notice in our waiting room and on our website. At any time, patients may review the current notice or request a paper copy by contacting our privacy officer.

V. COMPLAINTS

If you believe your privacy rights have been violated, we want to know and we want to make it right. If you believe this is the case, please notify us immediately. You may also file a complaint with our Privacy Officer or with the Secretary of the United States Department of Health and Human Services. *You will not be penalized or retaliated against in any way for filing a complaint.*