THE MODERN COUNTRY DOCTOR, LLC

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:

THE MODERN COUNTRY DOCTOR, LLC
Attn: Privacy Officer
23 Industrial Blvd., STE D
Paoli, PA 19301
(610) 890-8522

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 by 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 protect 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 <u>except when</u>: (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.

E. YOUR RIGHTS REGARDING YOUR IIHI:

The health and billing records we maintain are the physical property of the practice. 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.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to this request unless a law requires us to share that information. Patients of the practice characteristically pay out-of-pocket for services; therefore no Request for Restriction of PHI is necessary unless an insurer would request such PHI, in which case a Request for Restriction of Release of PHI to a Health Plan would be required from you.

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 The Modern Country Doctor, LLC, 23 Industrial Drive, Suite D, Paoli, PA 19301, 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 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 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 The Modern Country Doctor, LLC, 23 Industrial Drive, Suite D, Paoli, PA 19301. 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 The Modern Country Doctor, LLC, 23 Industrial Drive, Suite D, Paoli, PA 19301. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs. We will ordinarily act on

your accounting request within 60 days of your request. We are permitted to extend our response time for a period of up to 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 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:

THE MODERN COUNTRY DOCTOR, LLC.
Attn: Privacy Officer
23 Industrial Blvd., Suite D
Paoli, PA 19301
(610) 890-8522

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

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your 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.

THE MODERN COUNTRY DOCTOR, LLC

AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

The purpose of this form is to obtain your consent to participate in a telemedicine consultation with The Modern Country Doctor, LLC.

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1) **Purpose and Benefits:** The purpose of this form is to obtain your consent to participate in telemedicine consultation in connection with your general primary care or chronic healthcare needs.

2) **Nature of Telemedicine Consultation**: During the telemedicine consultation:

a) Details of your medical history, examinations, x-rays, and tests may be discussed with other health professionals using interactive video, audio and telecommunications technology.

b) Physical examination of you may take place.

c) Nonmedical technical personnel may be present in the telemedicine studio to aid in video transmission.

d) Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.

3) **Medical Information and Records:** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your explicit written consent, unless required by other existing confidentiality laws.

4) **Confidentiality**: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal and Pennsylvania state law apply to information disclosed during this telemedicine consultation. Per HIPAA guidelines The Modern Country Doctor has a signed Business Associates Agreement (BAA) that governs the preservation and maintenance of PHI in accordance with all HIPAA regulations.

5) **Risks and Consequences**: The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to physician contact. Participating in a telemedicine consultation does not represent a guarantee that all medical needs may be addressed. At the conclusion of the telemedicine visit your provider may advise you receive care either in-person or at another separate facility. In addition, if at any time your provider feels your life or health are under immediate threat, we reserve the right to notify appropriate emergency care services.

6) **Rights**: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

7) **Disputes**: You agree that any dispute arising from the telemedicine consultation will be resolved in Pennsylvania, and that Pennsylvania law shall apply to all disputes.

THE MODERN COUNTRY DOCTOR, LLC

I have been advised of all the potential risks, consequences and benefits of telemedicine. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

Signature:_____Date:_____
Patient (or person authorized to give consent)

If signed by person other than the patient, please indicate relationship:

Witness:_____Date:_____

APPENDIX A:

In accordance with current HIPAA guidelines and compliance The Modern Country Doctor, LLC and all staff communicate through HIPAA compliant channels. These communications may occur either by phone, app to app messaging within Elation EHR or Spruce Health, video calls, Spruce Visits, Secure Voicemail and Transcription and eFax. We do not as a routine communicate via standard email or SMS text messaging as there is a significant increase in the risk of third party interception of this information. The federal government has advised that you have the right to receive information via your preferred channels, including unencrypted channels, should you prefer them.

If you have a preference for additional means of communication, please provide your request, source and consent here and we will do our best to accommodate those preferences.

_____ _____

_____ _____

Signature: _____ Date:_____

THE MODERN COUNTRY DOCTOR, LLC

RELEASE OF INFORMATION AND FINANCIAL POLICY

Financial Policy:

Thank you for choosing The Modern Country Doctor, LLC as your health care provider.

If you have health insurance coverage:	If you do not have or choose not to use health insurance:
• You are responsible for supplying current, correct insurance information for covered services.	• Payment in full is due at the time of service.
• Please notify us of any changes in your physical address, email address or telephone number.	• We accept cash, Visa, MasterCard, Discover, American Express, Direct Debit, eCheck, Apple Pay, PayPal and VisaCheckout
• You are ultimately responsible for payment of all charges whether or not such charges are covered and paid (either fully or partially) by your insurance company.	
• All co-pays and your estimated portion, including any deductibles and/or co-insurances, will be expected at the time of service.	

Our business office is available from 8a - 4p, Monday through Thursday and 8a-2p on Friday to answer any questions or address any concerns you have. If you receive a statement from our office, then we expect payment from you. If you disagree with the balance for any reason please contact our business office immediately at (610) 890-8522. A $35.00 fee will be charged for all returned checks.

I hereby guarantee payment of all charges for medical treatment and services provided to me (or my dependent) by The Modern Country Doctor, LLC. I understand and agree that if the office places my account with an agency or attorney for collection, the offices shall be paid by me for all collection costs to the extent allowed by applicable law. I authorize the release of medical information to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I have read and agree to this financial policy:

Patient Signature:_____**Date:** _____

Card on File

By signing below, I authorize The Modern Country Doctor, LLC to keep my credit card information securely on-file in my account. I authorize The Modern Country Doctor, LLC to charge my credit card for any outstanding balances when due. If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give The Modern Country Doctor, LLC a new, valid credit card which I will allow them to charge over the telephone. Even though The Modern Country Doctor, LLC is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented.

Patient Signature:_____**Date:** _____

THE MODERN COUNTRY DOCTOR, LLC

Release of Information:

May we leave a message on your answering machine or voicemail regarding test results? Yes No

May we leave information regarding your medical care with someone other than you? Yes No

Please indicate with whom we can leave a message regarding appointments and test results:

Name:_____ Relationship:_____Phone #: _____

Name:_____ Relationship:_____Phone #: _____

Name:_____ Relationship:_____Phone #: _____

Patient Signature:_____Date: _____

Receipt of HIPAA Policy:

I acknowledge I have received or declined a copy of The Modern Country Doctor, LLC's Notice of Privacy Policy. This is available from our receptionist or on our website separately at:
https://moderncountrydoctor.com/legal/071920HIPAAnotice.pdf

Patient Signature:_____Date: _____

Telemedicine Consent:

I acknowledge I have received and completed a copy of The Modern Country Doctor, LLC's Telemedicine consent. This is available from our receptionist or on our website separately at:
https://moderncountrydoctor.com/legal/071920telemedconsent.pdf

Patient Signature:_____Date: _____