Please complete and sign enrollment forms and:

Fax to the Paladina Health Member Services team at 1-888-972-1735

OR

Mail them to: Paladina Health Member Services
1551 Wewatta St
Denver, CO 80202

Note: Everyone over the age of 18 must complete, sign, and submit a separate enrollment form. To enroll eligible dependents under the age of 18, complete the Dependent Information on page 2 of this form.

For questions, please call 1-866-808-6005 or email MemberServices@PaladinaHealth.com.
## Patient Information (Please complete one per member age 18 and older)

<table>
<thead>
<tr>
<th>Last Name:*</th>
<th>Legal First Name:*</th>
<th>M.I.:</th>
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<th>Nickname:</th>
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<tr>
<th>Address:*</th>
<th>Apt #:</th>
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<th>City:*</th>
<th>State:*</th>
<th>Zip:*</th>
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**Gender (M/F):**

<table>
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<tr>
<th>Employer:</th>
<th>Location (if applicable):</th>
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<table>
<thead>
<tr>
<th>Birth Date (mm/dd/yr):*</th>
<th>Social Security Number (SSN):*</th>
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<th>Email:*</th>
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<tr>
<th>Phone (mobile):</th>
<th>Phone (home):</th>
<th>Phone (work):</th>
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**Preferred phone (select one):**  
- [ ] Mobile  
- [ ] Home  
- [ ] Work

- [ ] It is ok to use this email address to send notices related to appointments, emails from my doctor and lab results. (Note: Emails will NOT include sensitive information such as mental health information or sensitive testing)
- [ ] It is ok to send text messages to my mobile phone (e.g., for appointment reminders)
- [ ] I want access to the Paladina Health Portal – where I can make online appointments, email my physician, view medical records and lab results, and more

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<thead>
<tr>
<th>Physician Name:</th>
<th>Clinic Location:*</th>
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<tr>
<th>Do you have Medicare as your primary insurance?*</th>
<th>Yes</th>
<th>No</th>
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<table>
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<tr>
<th>Do you receive Medicaid or state-provided medical assistance?*</th>
<th>Yes</th>
<th>No</th>
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<th>Do you (or an employer on your behalf) contribute to a Health Savings Account?</th>
<th>Yes</th>
<th>No</th>
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* Required information
Patient Acknowledgments (Please complete one per member age 18 and older)

By my signature below dated ____________________, 20____ (Effective Date), I hereby acknowledge that the following documents have been provided and/or made available to me and I agree to the following statements relating to such documents:

**Paladina Health™ Membership Agreement**
By signing below, I agree to be bound by the terms of the Membership Agreement (attached hereto) including the Detailed Service List (available at [www.paladinahealth.com](http://www.paladinahealth.com), at your Paladina Health™ clinic location, and through the Paladina Health™ Member Services team).

**Paladina Health™ Notice of Privacy Practices**
The Paladina Health™ Notice of Privacy Practices details how my personal health information may be used and disclosed as permitted under federal and state law. By signing below, I acknowledge that I understand and accept the contents of the Notice.

**Paladina Health™ Terms and Conditions**
I understand that the Paladina Health™ Terms and Conditions are an essential and integral part of this Membership Agreement. By signing below, I acknowledge that (i) the Paladina Health™ Terms and Conditions have been made available to me both electronically via the Paladina Health™ website and in hard copy at my Paladina Health™ clinic location and by contacting the Paladina Health™ Member Services team, and (ii) I have read and understand the Paladina Health™ Terms and Conditions including the disclosures contained therein.

By agreeing to these policies, I am agreeing for myself and for all enrolled dependents under age 18 for whom I am the legal parent, guardian or personal representative.

_____________________________________________ _________________________________________
Signature of Patient or Legal Guardian  Patient Name

### Dependent Information (Only List Those Under Age 18)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Birth Date (mm/dd/yr)</th>
<th>Social Security #</th>
<th>Provider Choice</th>
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Note: Dependents’ contact and mailing information are assumed to be the same as those of primary. Please contact memberservices@paladinahealth.com if you need to modify dependent information.
Please help us provide the most personalized care by completing the following health assessment. Please know that your information is always treated confidentially and with care.

### General
- **Height**: ____ feet _____ inches
- **Weight**: ____ pounds
- **Do you use tobacco products?** □ Yes □ No
- **Have you been admitted to the hospital in the past 12 months?** □ Yes □ No
- **Have you been admitted to the emergency room in the past 12 months?** □ Yes □ No

### Have you previously had or currently have any of the following conditions (check all that apply):

#### Circulatory System
- **Coronary Artery Disease** □ Yes □ No
- **Congestive Heart Failure (CHF)** □ Yes □ No
- **Heart Attack** □ Yes □ No
- **Hypertension** □ Yes □ No

#### Endocrine/Metabolic & Genitourinary
- **Diabetes** □ Yes □ No
- **High Cholesterol (Hyperlipidemia)** □ Yes □ No

#### Mental Health
- **Anxiety** □ Yes □ No
- **Bipolar** □ Yes □ No
- **Depression** □ Yes □ No
- **Schizophrenia** □ Yes □ No

#### Respiratory System
- **Asthma** □ Yes □ No
- **Chronic Bronchitis** □ Yes □ No
- **COPD** □ Yes □ No
- **Emphysema** □ Yes □ No

#### Musculoskeletal
- **Lower back pain** □ Yes □ No
- **Osteoarthritis** □ Yes □ No
- **Osteoporosis** □ Yes □ No

#### Renal Conditions
- **Chronic Kidney Disease** □ Yes □ No
Welcome to Paladina Health™! We are honored to be your partner and we are committed to delivering quality care and a great service experience.

1. Provider-Patient Relationship

By your signature, you acknowledge that you are voluntarily becoming a patient of Paladina Health™ affiliated providers and their medical group and/or practice (Paladina Health™). As a Paladina Health™ patient, those services described in Section 2 below will be made available to you pursuant to the terms of this Membership Agreement.

2. Our Services

Health Care Services: As a patient, you are eligible to receive a set of primary care, preventive care, and urgent care services as offered by your individual provider.

Concierge Services: As a patient, you are eligible to receive 24/7 mobile phone (for urgent care matters) and email access to provider, same or next-day appointments for urgent medical matters, and a low patient-to-provider ratio.

Paladina Health™ has prepared a Detailed Service List describing the available Health Care Services and Concierge Services, which is available for your review at www.paladinahealth.com, at your Paladina Health™ clinic location, and through the Paladina Health™ Member Services team. During the term of this Agreement, the Health Care Services and the Concierge Services provided by Paladina Health™ may be subject to change by Paladina Health™ from time to time. Such changes, if any, shall be reflected on the Detailed Service List.

By entering into this Membership Agreement, you acknowledge that Paladina Health™ does not provide comprehensive health insurance coverage. Paladina Health™ provides only the Concierge Services or Health Care Services specifically described herein.

3. Fees and Payment

Most, but not all of the services listed above at Section 2, are covered by a Comprehensive Monthly Fee, subject to the limitations set forth in this Membership Agreement. If you participate in a high-deductible health plan with a health savings account feature, you may be required to pay on a fee-for-service basis for certain primary care, non-preventive care and urgent care services until such time as your deductible has been satisfied. If you don’t pay on a fee-for-service basis for these services, you may lose your ability to contribute to your health savings account during your membership.

Paladina Health™ fees and payment terms and conditions vary depending on your health care coverage:

- If you are accessing Paladina Health™ through your employer or your health plan, please read and agree to the terms and conditions set forth in Section 3.A. You may skip Sections 3.B. and 3.C. (Please be aware that in the state of Washington, Paladina Health™ cannot enter into payment relationships whereby a health plan is responsible for paying the Comprehensive Monthly Fee.)

- If you are individually selecting Paladina Health™ to be your direct primary care provider without going through your employer or your existing health plan, please read and agree to the terms and conditions set forth in Section 3.B. You may skip Sections 3.A. and 3.C.

3.A. Employer/Health Plan Payment Responsibility

- If your employer or health plan has an arrangement with Paladina Health™ whereby your employer or health plan is responsible for paying the Comprehensive Monthly Fee to Paladina Health™, you will not be responsible for the Comprehensive Monthly Fee requirements in this Membership Agreement, and Paladina Health™ will not have any recourse against you for nonpayment of the Comprehensive Monthly Fee. In the event that the arrangement between Paladina
Health™ and your employer or health plan is terminated or you cease to be employed by your employer or covered by your health plan, this Membership Agreement shall remain in full force if you modify your then current Payment Responsibility to the appropriate condition (3.A, 3.B or 3.C as set forth herein).

- Some Health Care Services provided by Paladina Health™ are not covered by the Comprehensive Monthly Fee (Non-Covered Health Care Services). The Paladina Health™ fee schedule will be provided to you upon your request. Paladina Health™ may amend the fee schedule from time to time in its sole and absolute discretion and without prior notice.

- If you request and receive a Non-Covered Health Care Service, you can:
  - Pay for the services at the time the service is provided to you and request from Paladina Health™ a claim form that you may submit to your health plan (or other third party)
  - Authorize Paladina Health™ to submit a claim to be paid by your health plan (or other third party).

- If you authorize Paladina Health™ to submit a claim to be paid by your health plan or other third party, you hereby assign to Paladina Health™ your rights to receive payment from any third party for the provision of Health Care Services by Paladina Health™. You acknowledge and agree that Paladina Health™ may receive payments directly from any third party for the Non-Covered Health Care Services provided to you by Paladina Health™. You authorize Paladina Health™ to release any information needed to determine benefits payable by a third party or their agents. In the event that you receive any payment from a third party for a Non-Covered Health Care Service, you agree to turn over the payment in full to Paladina Health™.

3.B. Member Payment Responsibility:

- If your employer or health plan is not responsible for paying the Comprehensive Monthly Fee, you agree to pay $__ as a 1 (one) time enrollment fee and the Comprehensive Monthly Fee indicated below:
  - $___ per month for persons age under 18 (eighteen)
  - $___ per month for persons age 18 (eighteen) and over

- Paladina Health™ will not bill your health insurance plan for the Comprehensive Monthly Fee or for any individual services that are covered by the Comprehensive Monthly Fee. The Comprehensive Monthly Fee is subject to change by Paladina Health™ at any time upon 60 days’ prior written notice (via U.S. mail, facsimile or email) to you. If you elect not to accept the change in the Comprehensive Monthly Fee and, in turn, terminate this Agreement, you may do so in accordance with the termination provisions set forth in Section 6 below.

- Some Health Care Services provided by Paladina Health™ are not covered by the Comprehensive Monthly Fee. The Paladina Health™ fee schedule will be provided to you upon your request. Paladina Health™ may amend the fee schedule from time to time in its sole and absolute discretion and without prior notice.

- If you request and receive a non-covered Health Care Service, you can:
  - Pay for the services at the time the service is provided to you and request from Paladina Health™ a claim form that you may submit to your health plan (or other third party)
  - Authorize Paladina Health™ to submit a claim to be paid by your health plan (or other third party).

- If you authorize Paladina Health™ to submit a claim to be paid by your health plan or other third party, you hereby assign to Paladina Health™ your rights to receive payment from any third party for the provision of Health Care Services by Paladina Health™. You acknowledge and agree that Paladina Health™ may receive payments directly from any third party for the non-covered Health Care Services provided to you by Paladina Health™. You authorize Paladina Health™ to release any information needed to determine benefits payable by a third party or their agents. In the event that you receive any payment from a third party for a non-covered Health Care Service, you agree to turn over the payment in full to Paladina Health™.
3.C. Medicare Beneficiary Payment Responsibility:

- Paladina Health™ is not a Medicare-participating provider. However, Health Care Services may still be provided to Medicare beneficiaries at certain locations, as some Paladina Health™ affiliated providers and their medical groups and/or practices have “opted-out” of Medicare. This means that all services provided by these particular “opted-out” providers and their medical groups and/or practices to Medicare beneficiaries are not covered by Medicare. In this situation Medicare beneficiaries may choose to enter into a private contract with the opted-out Paladina Health™ affiliated provider(s) agreeing, in addition to other terms, to accept full responsibility for payment of the opted-out providers’ charges for all services furnished by that opted-out provider. If you are enrolled in Medicare or if you become enrolled in Medicare or if you participate in any other governmental medical care programs (including Medicaid), please notify us immediately.

⇒ **Charge Date**: All member charges described in this Section 3, including, as applicable, the Comprehensive Monthly Fee, the Monthly Concierge Fee, and applicable member responsibility amounts including copayments and deductibles shall be charged to you each month or pursuant to such other charge schedule as determined by Paladina Health™.

4. Your Medical Information

Your privacy is very important to us and you control the use of your personal information. Paladina Health™ has put important safeguards in place to make sure your medical information is protected and safe to maintain its confidentiality.

Paladina Health™ seeks to work together with you to give you the best health care possible. Having access to your medical information will help your Paladina Health™ doctor give you the best possible care because he/she will have the most up-to-date information about your health. Therefore, as allowed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and to help us give you the right care, in the right place and at the right time, Paladina Health™, your employer sponsored group health plan and its contractors and agents (Health Plan) may electronically share with us your health-related information (including your “protected health information” as defined by HIPAA). Such shared health-related information may include things like visits to the doctor or hospital, Paladina Health™, medical conditions, current and past prescriptions, biometric data (height, weight, body fat percentage, etc.) and other health status-related information.

5. Digital Communication Risks and Conditions

Paladina Health offers members the ability to send and receive emails to and from their care team. While Paladina Health takes many precautions to protect your information and the security of the emails it sends, there are still risks.

**Risks:**
Transmitting patient information by email has a number of risks. These risks include but are not limited to the following:

- Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Email senders can readily misaddress an email.
- Email can be intercepted, altered, forwarded or used without authorization or detection.
- Emails may not be secure, and therefore it is possible that the confidentiality of such communications may be breached by a third party.
- Email service providers may have access to your emails.

**Conditions:**
Paladina Health is not liable for improper disclosure of confidential information that is not caused by Paladina Health’s misconduct. You must acknowledge and consent to the following conditions:

- Email is not appropriate nor should it be used for urgent or emergency situations.
• Per your request, Paladina Health may send emails to you as necessary for your diagnosis, treatment, billing, eligibility and other handling. You should not use email for sensitive communications (e.g., AIDS/HIV, mental health, developmental disability or substance abuse).

• You are responsible for informing Paladina Health, in writing, if you want to cease or limit email communications with Paladina Health. You may do so at any time without reason or explanation.

• You are responsible for protecting your email account password or other means of access to your email. Paladina Health is not liable for breaches of confidentiality involving your email account that are caused by you or any third party.

By signing this Membership Agreement, you acknowledge that you have received and read the above information. In addition, you agree to any instructions that Paladina Health may impose regarding the sending and receipt of email communications containing patient information.

Recommendations and Instructions:
If you wish to send and receive emails from Paladina Health regarding your care and treatment, you:

• Should limit or avoid use of public computers and public networks.
• Should promptly inform Paladina Health of changes in your email address.

• Before sending emails containing personal health information to Paladina Health, you should:
  o Ensure the email is addressed to the intended recipient.
  o List the key topic in the subject line.
  o Put your name in the body of the email.
  o Take precautions to preserve the confidentiality of your emails. Once Paladina Health sends an email from its network, it has no control over its confidentiality or security.

6. Terms and Termination

This Membership Agreement shall begin upon the Effective Date and shall continue until such time as it is terminated pursuant to this Section 6.

You may terminate this Membership Agreement once each calendar month during the Agreement’s term. Such opportunity shall be the monthly date that coincides with the Effective Date (the Monthly Termination Date). For example, if the Effective Date is the 15th (Fifteenth) of March, each Monthly Termination Date shall be the 15th (Fifteenth) of each successive month. Notwithstanding the foregoing, in order to terminate this Membership Agreement as of a Monthly Termination Date, you must complete, sign and submit (via U.S. mail, overnight carrier, email or fax) to Paladina Health™ a Membership Cancellation Form at least 21 (twenty-one) days prior to the applicable Monthly Termination Date. Membership Cancellation Forms can be obtained via the Paladina Health™ member portal, at a Paladina Health™ clinic, or by contacting Paladina Health™ Member Services team.

No refunds shall be made if you terminate this Membership Agreement as all Fees paid are non-refundable. This includes all Fees that may have been paid whether such were paid on a monthly, quarterly or annual basis. Upon cancellation, after payment is received for all periods prior to the termination of this Membership Agreement, you will not be responsible for any further payments.

Paladina Health™ may terminate this Membership Agreement at any time, subject to any professional obligations. Additionally, if a Member is personally responsible for the Comprehensive Monthly Fee per Section 3.B above and fails to timely make the monthly payment, Paladina shall give notice to Member and provide 10 (ten) days to cure this non-payment. If payment has not been made within the cure period Paladina may terminate this Agreement immediately, with notice to the Member.

7. Our Terms

• If any term, provision, covenant or condition of this Membership Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions will remain in full force and effect and will in no way be affected,
impaired or invalidated.

- This Membership Agreement will be governed by and construed in accordance with the laws of the state in which the medical office of your Paladina Health™ physician is located.

- This Membership Agreement is non-transferable.

If you have a complaint, please contact your Paladina Health™ clinic directly or in any of the following ways:

Email: MemberServices@paladinahealth.com
Phone: 1-866-808-6005

Mail: Paladina Health™
Attn: Member Services
1551 Wewatta Street
Denver, CO 80202
Notice of Privacy Practices                                      Effective Date: June 22, 2014

WE WILL MAINTAIN A RECORD OF YOUR HEALTH INFORMATION AND WE WILL PROTECT THE PRIVACY
OF YOUR HEALTH INFORMATION IN ACCORDANCE WITH THE LAW AND PURSUANT TO THE TERMS OF
THE PRIVACY NOTICE.

WE WILL PROVIDE YOU A PAPER COPY OF THE PRIVACY NOTICE UPON YOUR REQUEST. YOU MAY
OBTAIN A PAPER COPY OF PRIVACY NOTICE BY CONTACTING PRIVACY@PALADINAHEALTH.COM OR
CALLING 1-866-808-6005.

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

Our Pledge Regarding Medical Information

Your health information is personal, and we are committed to protecting it.

We keep a record of the healthcare services we provide you. You may ask us to see and copy that record. You may
also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless
the law authorizes or compels us to do so. This notice applies to all of the records of your care.

If you have any questions about this notice, please contact privacy@paladinahealth.com

We are required by law to:

- Make sure that medical information that identifies you is kept private (with certain exceptions);
- Provide you a notice of our legal duties and privacy practices with respect to your health information;
- Provide you with notice of a breach of your unsecured protected health information; and
- Follow the terms of the notice that is currently in effect.

We may use or disclose your health information, in certain situations, without your consent or authorization. Such
uses and disclosures may be in oral, paper or electronic format. Below we describe examples of how we may use or
disclose your health information as permitted under or required by federal law, including instances where we will
obtain your consent or authorization. The following categories describe different ways that we use and disclose
medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are
permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use and disclose your health information to provide you with medical treatment or services
or to assist in the coordination, continuation or management of your care and any related services. This includes the
coordination or management of your health care with a third party. For example, a health care provider, such as a
physician, nurse, or other person providing health services to you, will record information in your record that is related
to your treatment. This information is necessary for other health care providers to determine what treatment you
should receive.

For Payment. We may use and disclose your health information to others for purposes of obtaining payment for
treatment and services that you receive. For example, we may disclose to your employer that you are one of our
patients so that your employer will pay your monthly fees for care.

For Health Care Operations. We may use and disclose health information about you for operational purposes. For
example, your health information may be used by Paladina Health™ or disclosed to others in order to:

- Communicate with you about our activities and locations;
- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your case and similar cases;
- Learn how to improve our facilities and services;
- Determine how to continually improve the quality and effectiveness of the health care we provide; and
- To notify your employer that you have achieved program requirements in order to get a discount on
  your insurance premium.
Communications. We may use and disclose your information to provide appointment reminders, leave a message on your answering machine, or leave a message with an individual who answers the phone at your residence. We may, from time to time, contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Required or Permitted by Law. We may use and disclose information about you as required or permitted by law. If a use or disclosure is required by law, the use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. If required by law, you will be notified of any such uses or disclosures. For example, we may use and/or disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence;
- To assist law enforcement officials in their law enforcement duties;
- In the instance of a breach involving your unsecured health information, to notify you, law enforcement and regulatory authorities, as necessary, of the situation, and others as appropriate to help resolve the situation; or
- To health oversight agencies responsible for monitoring the health care system and government programs.

Public Health. Your health information may be used or disclosed for public health activities such as: (1) assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability; (2) reporting child abuse or neglect to a public health authority or other governmental authority that is authorized by law to receive such reports; (3) reporting information to a person subject to the jurisdiction of the Food and Drug Administration (FDA), for public health purposes related to the quality, safety or effectiveness of FDA-regulated products or activities such as collecting or reporting adverse events, dangerous products, and defects or problems with FDA-regulated products; (4) notifying a person who may be at risk of contracting or spreading a disease, if such disclosure is authorized by law; (5) reporting information to your employer, for the purposes of conducting an evaluation of medical surveillance of the workplace or for the purposes of evaluating whether you have a work-related illness or injury; or (6) disclosing proof of immunization to your school, or your child’s school, if the school is required by law to have such proof prior to admitting you or your child. We will obtain and document your agreement to such immunization disclosures.

Individuals Involved in Your Care. We may provide information about you to a family member, friend, or other person involved in your health care or in payment for your health care, if you do not object, or in an emergency. If you are deceased, we may disclose medical information about you to a friend or family member who was involved in your medical care prior to your death, limited to information relevant to that person’s involvement, unless doing so would be inconsistent with your written wishes you previously provided to us. If we disclose information to a family member, relative or close personal friend, we will disclose only information that we believe is relevant to that person’s involvement with your health care or payment related to your health care.

Health and Safety. We may, consistent with applicable law and standards of ethical conduct, use or disclose health information about you if we believe that the use or disclosure is necessary to prevent or lessen a serious threat to the health or safety of a person or the public; provided that, if a disclosure is made, it must be to a person(s) reasonably able to prevent or lessen the threat. We may also use or disclose your health information if we believe that the use or disclosure is necessary for law enforcement authorities to identify or apprehend an individual who: (i) admits to participation in a violent crime that we reasonably believe caused serious physical harm to the victim, or (ii) appears to have escaped from a correctional institution or lawful custody.

Notification and Disaster Relief. We may use or disclose your health information to notify or assist in notifying your family, a personal representative, or another person responsible for your care, of your location, condition, or death. We may disclose your health information to disaster relief authorities so that your family can be notified of your location and condition.

Correctional Institutions. If you are an inmate or in the custody of law enforcement, we may disclose your health information to correctional institutions or law enforcement for such purposes as providing care, for the health and safety of yourself or others, for law enforcement at the correctional facility, or for maintenance of safety, security and order at the facility in accordance with state and/or federal regulations.

Decedents. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about you to funeral directors as necessary to enable them to carry out their lawful duties. Once you have been dead for 50 years (or such other period as may be specified by law), we may use and disclose your health information without regard to the restrictions set forth in this Notice.
Organ/Tissue Donation. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation and transplantation purposes.

Government Functions. We may disclose your health information for specialized government functions, such as military and veteran’s activities, national security and intelligence activities, and protection of public officials.

Workers’ Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers’ Compensation.

Business Associates. We may contract with one or more third parties (our business associates) in the course of our business operations. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. We require that our business associates sign a business associate agreement and agree to safeguard the privacy and security of your health information.

Consents And Authorizations For Other Uses

While we may use or disclose your health information without your written authorization as explained above, there are other instances where we will obtain your written authorization. Except as otherwise provided in this Notice, we will not use or disclose your health information without your prior written authorization. You may revoke an authorization at any time, except to the extent we have already relied on the authorization and taken action.

Examples of uses and disclosures that require your authorization are:

Marketing. Except as otherwise permitted by law, we will not use or disclose your health information for marketing purposes without your written authorization. However, in order to better serve you, we may communicate with you about refill reminders and alternative products. Should you inquire about a particular product-specific good or service, we may provide you with informational materials when you come in for your treatments. We may also, at times, send you informational materials about a particular product or service that may be helpful for your treatment.

No Sale of Your Health Information. We will not sell your health information to a third party without your prior written authorization.

Uses and Disclosures of Your Highly Confidential Information. Some federal and/or state laws require special privacy protections for certain highly confidential health information, relating to: (1) psychotherapy services; (2) mental health and developmental disabilities services; (3) alcohol and drug abuse prevention, treatment and referral; (4) HIV/AIDS testing, diagnosis or treatment; (5) venereal disease(s); (6) genetic testing; (7) child abuse and neglect; (8) domestic abuse of an adult with a disability; and/or (9) sexual assault. Unless a use or disclosure is permitted or required by law, we will obtain your written consent or authorization prior to using or disclosing your highly confidential health information to third parties.

Your Rights Regarding Health Information About You

You have the following rights regarding your health information. To exercise any of the rights below, please contact your Paladina Health clinic to obtain the proper forms.

You have the right to:
- Request a restriction on the uses and disclosures of your information for treatment, payment and health care operations or request a limit on the health information we disclose about you to someone involved in your care or the payment for your care, like a family member or a friend:
  - If you have paid for a service or health care item out-of-pocket in full, and you ask us not to share that information with your health insurer for purposes of payment or our operations (not treatment), we will agree with your request unless a law requires us to share information. For all other requests, we will consider your request. For these:
    - Your request must be in writing, and we will notify you of our decision in writing.
    - If we do agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment.
    - Except for restrictions that we must comply with relating to health plans, we may terminate our agreement to a restriction at any time by notifying you in writing, but our termination will only apply to information created or received after we sent you the notice of termination, unless you agree to make the termination retroactive.
• Obtain a paper copy of the Notice of Privacy Practices upon request. You may obtain a paper copy of this Notice by contacting privacy@paladinahealth.com. The Notice is also available at your Paladina Health™ clinic.

• Inspect and obtain a copy of your health and billing records. You have the right to receive your clinical diagnostic laboratory test results directly from Quest, LabCorp or DynaCare. All requests to inspect or copy your health information or to access directly your clinical diagnostic laboratory test results must be in writing. We can provide a form for you to use. In certain circumstances, we may deny your request for inspection or copying, but if we do, we will notify you in writing of the reason(s) for the denial and explain your right to have the denial reviewed. If the information is maintained electronically and if you request an electronic copy, we will provide you with an electronic copy in the form and format requested by you, if it is readily producible in that form and format (if it is not, then we will agree with you on a readable electronic form and format). You can direct us to transmit the copy directly to another person if you submit a signed written request that identifies the person to whom you want the copy sent and where to send it. If you request copies, we may charge a reasonable cost-based fee for the labor involved in copying the information, the supplies for creating the paper copy or the cost of the portable media, postage, and providing a summary of your records, if you request a summary.

• Request an amendment to your health information. You may request that your health record be amended if you believe that the health information we have about you is incomplete or incorrect. Requests to amend your health information must be in writing. We can provide a form for you to use. We may deny your request and if we do, we will notify you in writing of the reason for the denial and your right to submit a statement disagreeing with the denial.

• Request confidential communications. You have the right to ask us to communicate health information to you using alternative means or at alternative locations. Such requests must be in writing. We can provide a form for you to use. We will accommodate reasonable requests and will notify you if we are unable to agree to your request.

• Receive an accounting of disclosures of your health information. You have the right to obtain a list of instances in which we have disclosed your health information except in certain instances. These instances include: disclosures for treatment, payment and health care operations; disclosures made to you; disclosures incident to a use or disclosure permitted or required by the Federal HIPAA Privacy Rule; disclosures authorized by you; disclosures to persons involved in your care or to disaster relief authorities; disclosures for national security and intelligence purposes; disclosures to correctional institutions or law enforcement officials; disclosures that are part of a limited data set; and disclosures occurring more than six years prior to the date of your request. Your request must be in writing. We can provide a form for you to use. The list will not include disclosures made prior to April 14, 2003, those made for treatment, payment, healthcare operations purposes (except as described below), certain disclosures required by law, and disclosures made to, or authorized by, you. After January 1, 2014 (or a later date as permitted by HIPAA), the list will include disclosures made for treatment, payment or healthcare operations using our electronic health record. The first disclosure list in a year is free; if you request additional lists in any year we may charge you a fee.

Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. Unless otherwise required by law, the revised Notice will be effective on the new effective date of the Notice. The current Notice will be available on our website and in the reception area of all Paladina Health™ locations.

Complaints

If you have questions, want more information, or want to report a problem about the handling of your health information, please send us an email at privacy@paladinahealth.com or call 1-866-808-6005. You may also file a complaint with the U.S. Secretary of Health and Human Services. The privacy officer can give you information about filing a complaint. If you complain, we will not reduce your level of service because of it or retaliate against you.